

WASHINGTON SCHOOL OF PSYCHIATRY

**An Intensive Study of Twelve Cases of
Manic-Depressive Psychosis**

Final Report on Office of Naval Research Contract

Nonr-751 (00)

September 30, 1953

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TABLE OF CONTENTS

	<u>Page</u>
I. Introduction	1
II. Survey of the Literature	4
III. Family Background and Character Structure	42
IV. Differential Diagnosis of the Manic Depressive	72
V. Problems in Therapy; Transference and Counter- Transference	78
VI. Case Reports	102
Case 1: Mr. R.	102
Case 2: Miss G	127
Case 3: Mr. H	152
Case 4: Mrs. C	184
VII. Summary and Conclusions	224

I. INTRODUCTION

The purpose of this study is to examine the manic-depressive character by means of the intensive psychoanalytic psychotherapy of a number of patients. We felt this to be potentially useful since the newer understanding of inter-personal processes and of problems of anxiety has not hitherto been brought to bear on this group of patients. The older psychoanalytic studies of the psychopathology of the manic depressive have been largely static in the sense that they have described the intra-psychic state of the patient and left unexplained the question of how the particular pattern of maladjustive behavior has arisen. Thus, to use a simple example, the manic depressive is said to have an oral character. However, the question of how or why he developed an oral character is left unconsidered, except that such factors as a constitutional over-intensity of oral drives, or over-indulgence or frustration during the oral phase, are mentioned. Our purpose is to delineate as far as possible the experiences with significant people which made it necessary for the prospective manic depressive to develop the particular patterns of interaction which comprise his character and his illness. To this end, both constitutional factors and single traumata, while not denied significance, are not stressed. Rather, we have assumed that the interpersonal environment from birth has operated to affect the development of the manic-depressive character in the child. In other words, the personality of the parents, the quality of their handling of the child, and the quality

of the child's response to this handling have eventuated in a characteristic pattern of relating to others and reacting to anxiety-arousing situations which we call typical of the manic-depressive character.

Such a study has many implications for the improvement of the therapeutic approach to the patient. We follow the basic premise of psychoanalytic theory - that in the transference relationship with the therapist the patient will repeat the patterns of behavior which he has developed with significant figures earlier in his life. By studying the transference, we can make inferences about earlier experiences; conversely, by understanding the patient historically, we can make inferences about the transference relationship. As our grasp of the patient's part of the pattern of interaction with his therapist improves, we can gain some concept of what goals of satisfaction he is pursuing, as well as of what sort of anxieties he is striving to cope with. We may then intervene through our part in the interaction to assist him more successfully to achieve his goals of satisfaction and to resolve some of the conflicts which are at the source of his anxiety.

In this research project, a total of twelve cases were studied. They were all treated by intensive psychoanalytic psychotherapy for periods ranging from one to five years. The present Navy-sponsored research grew out of a seminar which had gone on for three years previously, during which nine of the cases were presented and

studied.^{1/} During the two years of Navy sponsorship, three cases were studied in great detail by the present research group, which met twice monthly for three-hour sessions. These three cases are reported in detail in the final section of this report, together with one of the earlier cases which was selected because of features of particular interest. These detailed case studies are included in order to provide substantiating and illustrative material for the points brought out in the report. The other cases are referred to in brief in the body of the report.

^{1/} A preliminary report of the work of this seminar will be found in: Fromm-Reichmann, Frieda: Intensive Psychotherapy of Manic Depressives. Confinia Neurologica, 1949, 9, 158-65. The members of the original seminar were: Doctors Grace Baker, Mabel Cohen, Robert Cohen, Frieda Fromm-Reichmann, Robert Morse, David Rioch, Olive Smith, Alfred Stanton, Herbert Staveren, Sarah Tower, Benjamin Weininger, and Mary White. Our thanks and appreciation are due to the other members of the seminar for their contribution to this project, as well as to Mrs. Jane Burkhardt and Mrs. Helen Perry for their secretarial and editorial assistance.

II. SURVEY OF THE LITERATURE

At the end of the last century Kraepelin established the manic-depressive psychosis as a nosological entity. While classification created a beneficial order in the pre-existent confusion of psychiatric syndromes, neither his dementia praecox nor his manic-depressive psychosis fulfill the essential expectations which the physician connects with the concept of a nosological entity; in fact, there has not yet been discovered a pathological substratum, nor a specificity of etiological factors responsible for these illnesses.

Manic or depressive syndromes appear in exogenous psychoses, general paresis, brain injuries, involutional and epileptic illnesses, as well as in hysteric and obsessional neuroses. The differential between schizophrenia and manic-depressive psychosis is particularly difficult, and has frequently become a controversial issue between different psychiatric schools. N. D. C. Lewis and L. D. Hubbard, as well as Paul Hoch and H. L. Rachlin, have pointed out that a percentage of originally diagnosed manic depressives later on have had to be reclassified as schizophrenics. More infrequent is a reversal of the diagnosis of schizophrenia into that of manic-depressive psychosis. Nevertheless, typical cases of the manic-depressive, or circular, psychosis, as Kraepelin first described it, do exist, side by side with a great number of atypical cases. Kraepelin's statistics, verified by similar figures of

J. Lange, show in the group of circular psychoses 49 percent intermittent melancholias, 17 percent intermittent manias, and 35 percent of cases in which melancholic and manic episodes alternate. There are more women than men suffering from manic-depressive psychosis. Kraepelin considered the purely manic states and the purely depressive states, as well as episodes of mixed manic and depressive symptomatology, to be atypical incidents of the typical manic-depressive psychosis.

The apparent lack of specificity of etiological factors in manic-depressive psychosis stimulated Bellak to propose a "multiple factor psychosomatic theory of manic-depressive psychosis," since anatomical, endocrine, genetic, infectious, neurophysiological and psychological factors may contribute to the provocation of manic and depressive syndromes. Sullivan also subscribes to this general approach to manic-depressive psychosis; the fact that he stresses the importance of physical factors in this illness is particularly interesting since he has stressed dynamic psychogenic factors in the schizophrenic. Bellak views a continuum from normality, through neurotic and psychosomatic illnesses, to the extreme forms of fully developed psychosis. In this continuum, quantitative factors establish an equilibrium between integrating and disintegrating forces on different levels, where quantity changes into quality. The quality of an illness, according to Bellak, depends on the quantity of integrating forces (ego strength) in relation to disintegrating forces from

within and without. His theory is in accord with Freud's theory about the relation of constitutional factors, dispositional factors of early childhood experiences, and actual provocation of an illness. In "Analysis Terminable or Interminable," Freud said: "We have no reason to dispute the existence and importance of primal, congenital ego variations." The importance of the integrating forces (ego strength) corresponds to H. Goldstein's gestalt view of brain action. It is well known that the ego strength of the manic depressive may be importantly influenced by genetic factors. Studies on the high incidence of manic-depressive illnesses in the same family, which cannot be considered only as the result of environmental influences, the genetic research which followed E. Kretschmer's description of the pyknic body shape and its coincidence with the manic-depressive type, and the research on identical twins with manic-depressive psychoses focus primarily on the genetic factors in this illness.

We are in our studies particularly interested in pursuing the part that psychodynamic factors play in bringing about the manic-depressive illness. But we agree with S. Rado that the multiplicity of etiological factors calls for close collatoration of pathologists, neuro-physiologists, endocrinologists, geneticists, psychiatrists, and psychoanalysts. In the long run, better team-work by these specialists may improve inconsistent methods of therapy now applied, varying from

custodial care with sedation, to prolonged narcosis (J. Klaesi), different forms of shock therapy, lobotomy, and occasionally various forms of psychotherapy. Our ignorance about the etiology of manic-depressive psychosis is reflected in the haphazard application of shock therapy and lobotomy, the effects of which still remain in the realm of speculation. We will find, in the course of our study, many speculative elements in the psychotherapeutic approach, too. But psychotherapeutic experimentation abides, or tries to abide, by the medical standard of "nihil nocere."

Description of Typical Manic-Depressive Psychosis

Since we have set ourselves the goal of contributing to the elucidation of the psychodynamics of manic-depressive psychoses, our historical survey will collect particularly the data that psychoanalysts are able to furnish. But before beginning this historical survey, we would like to give a short description of typical manic-depressive psychosis, as we have gleaned it from the writings of psychiatrists who are particularly interested in the phenomenological aspect of the illness. In this respect, we are particularly impressed by L. Binswanger, von Gebattel, E. Minkowski, and Erwin Strauss. Henry Ey has gathered a great number of these phenomenological descriptions together in his "Psychose Periodique ou Maniaco-Depressive," (1949) from which we make a short resume. In the phenomenological analysis of manic-depressive psychoses, there is a uniform emphasis on the regressive dissolution

of the synthetic functions in the morbid personality. In the manic attack, the lowered level of integration is mainly expressed by the flight of ideas, which has been excellently described and analyzed in a monograph by Binswanger--Ueber Ideenflucht. In the manic, intuition supersedes rational thought processes. Expansive superficiality and lack of concentration of attention carry the stream of verbal utterances to the point of incoherence. Constructive, creative impulses miscarry. Work sinks to the level of play. Even in the angered, furious manic, the observer can spot playful, theatrical elements. The manic remains extremely distractible even when his consciousness is beclouded by daydreaming preoccupations; he remains directed toward the outside world; he abandons himself to reality. Sleep is frequently disturbed, as it is also in the depressive phase. The subjective experience of time is accelerated in the manic patient. The anarchic display of primitive emotions indicates a decrease in the controlling functions. Heteroerotic, homoerotic, aggressive, angry, enraged, and fearful impulses are turned loose, but none of them lasts long. The delusional distortions of judgment are found in a distorted self-appraisal with ideas of grandeur, omniscience, and omnipotence; furthermore, the obstacles of reality are minimized, denied, circumvented, in hyperactive, but ineffective, short-cut solutions, although the ineffectiveness is subjectively denied. Never is there the cold withdrawal from the outside world which characterizes the schizophrenic.

In the depressive attack, the lowered level of integration is experienced as absolute failure, with feelings of anguish and despair. The anguish may produce an aimless restlessness, agitation; and the despair slows down all mental activities. The melancholic feels impoverished, empty; his speech is scanty, his self-expression is reduced to moaning and gestures of utmost desolation. All his interests are narrowed to a monotonous preoccupation with self-devaluation, grotesquely exaggerated self-accusations, convulsive contrition. One may discover an element of grandeur similar to the manic's in the monstrosity of his self-accusations, as if the patient considered himself the greatest criminal in the world. In subjective experience, time creeps unbearably slowly. Even where there is no agitated preoccupation with doubts and indecisions, there is the feeling of a painful inner void, related to experiences of self-estrangement and depersonalization, which overshadows the outside world, making it look flat and colorless. Food is tasteless and frequently rejected. There are also occasional depressions with avid over-eating. Instead of the anarchy of expansive emotions in the manic, the depressive seems to be dominated by a similarly uncontrollable concentration of all emotional energies on self-torture. But this does not mean that the depressive withdraws from reality as the schizophrenic does. Even in the blackest depth of anguish and despair, the melancholic reaches out for help;

although effective help may not be available, he reaches out in monotonous complaints or entreating gestures. He may even pester his environment and make himself very unpopular. But accusations of others appear very seldom in typical melancholias. Ideas of reference are mostly secondary results of the all-pervading sense of unworthiness and desolation. The melancholic loses weight. He wants to disappear, annihilate himself. All his ingenuity may be concentrated on finding a means of self-destruction. He may feel driven toward death with irresistible violence. Binswanger has described a melancholic patient, in "Der Fall Ellen West" (the diagnosis was later changed to schizophrenia, because of extreme inaccessibility): this patient, after having gone through years of demonic self-torturing eating impulses, and rigorous fasting compulsions, became completely free and serene at the moment she arrived at the ultimate decision of killing herself, some hours before a successful suicide.

Psychoanalytic Research

We turn now to the history of psychoanalytic research in the circular psychoses. After some abortive attempts by Alphonse Maeder, A. A. Brill, and E. Jones, Karl Abraham in 1911 was the first to systematically apply the psychoanalytic method to the treatment of manic-depressive psychoses. He came to the conclusion that manic and depressive phases are dominated by the same complexes, the depressive

being defeated by them, the manic ignoring and denying them. The regression to the oral level of libido development brings out the characterological features of impatience and envy, increased egocentricity, and intense ambivalence. The capacity to love is paralyzed by hate. The depressive stupor represents a form of dying. The impaired ability to love leads to feelings of impoverishment. The indecision of ambivalence is close to the doubts of the compulsive neurotic. In the free interval, the manic depressive is an obsessional neurotic, and Abraham recommends psychoanalysis in this free interval, since, in the acute phases of the psychosis, it is very difficult to establish rapport.

In 1921, Lucile Dooley continued Abraham's experiment in this country by studying, psychoanalytically, five manic-depressive patients in St. Elizabeths Hospital. Like Abraham, she found considerable resistance in her patients' extraverted egocentricity, for which she accepted W. A. White's concept of "flight into reality." According to White, this tendency toward extraversion of libido makes the prognosis of manic-depressive psychosis more favorable, in terms of spontaneous recovery, than that of schizophrenia. Because of the dominance of his egocentric wishes, the manic-depressive patient can make "use of every object in range of his senses." But Dooley found that the resistances of the manic-depressive against analysis are even stronger than those in

schizophrenics. The manic attack appears to Dooley as a defense against the realization of failure. The patient cannot look at himself in the mirror of psychoanalysis; he cannot hear the truth. "Patients who manifest frequent manic attacks are likely to be headstrong, self-sufficient, know-it-all types of person, who will get the upper hand of the analyst. . . . The analyst is really only an appendage to a greatly inflated ego." Life conditions not being more unsatisfactory than those of many a normal person, there must be a lack of integration that does not allow the manic depressive to achieve the sublimations which he is potentially capable of. Dooley came to the result that the manic and depressive episodes are due to deep regressions to the sadomasochistic level of the child. "Autoerotic wishes were satisfied by hypochondriacal complaints." In a much later paper on "The Relation of Humor to Masochism," (stimulated by Freud's book, Wit and Its Relation to the Unconscious, and his essay, "Humour") Dooley mentions a manic-depressive patient who began to develop humor in the analysis as the patient became aware that she "could neither hurt me, nor wangle me into loving her." This kind of insightful humor is a milestone in the healing process of the excessive moodswings; it indicates that the super-ego loses its tragically condemning cruelty and permits laughter at the overweening, pestering child-ego.

Parallel with the early therapeutic experimentations with manic-depressive psychoses, a reorientation in the libido theory took

place. In 1914, Freud had broadened the original dualistic instinct theory--object libido versus ego instincts--by introducing the concept of narcissistic libido. From the reservoir of primary libido, the object cathexes are sent out like the pseudopodia of the ameba. Secondary withdrawal of frustated object libido into the ego instead of into the phantasy representation of lost objects (the pre-condition for sublimation) does not lead to a support of the ego drives in the sense of healthy self-assertion, but to a stagnation and accumulation of narcissistic libido and therewith to the symptom formations of the narcissistic neuroses or functional psychoses, delusions of guilt, hypochondriasis, and delusions of grandeur. This reorientation in the theory of instincts smoothed the path for the psychoanalytic study of psychoses in which the narcissistic object choice, with the preference for relations of introjection and projection, is founded on constitutional elements or factors of early life experience.

In 1916-17, Freud compared melancholia to normal mourning. The loss of a love object elicits the labor of mourning. In the case of melancholia, this loss in form of separation, disappointment, or frustration, remains unconscious. The labor of mourning is a struggle between libido attachment and detachment, love and hate; this struggle of ambivalence under the pressure of controntation with reality leads to gradual rechannelization of libido toward new objects. But in the melancholic person, this reorientation exacted by reality elicits strong

resistances, since the narcissistic character of the disturbed relation does not permit detachment; in this way, an intensified identification with the frustrating love object in the unconscious results. "The shadow of the object has fallen on the Ego." The whole struggle of ambivalence is internalized in a battle with the conscience. The exaggerated self-accusations are reproaches against the internalized object of love and hate; the self-torture is a form of revenge, and simultaneously, an attempt at reconciliation with the internalized partner. The narcissistic, ambivalent character of the relation to the lost love object is either the result of transitory regression or is constitutionally conditioned. Thus the loss of self-esteem and intense self-hate in the melancholic becomes understandable.

In 1921, in his Group Psychology and the Analysis of the Ego, Freud added some statements about mania to his interpretation of depression made earlier. He described the manifold identifications of each individual with groups and their leaders, which influence the development of the ego. The ego ideal or superego, the heir of the primary narcissism, is the inner representative of these identifications. The mood swings of the normal and neurotic individual are caused by the tensions between ego and ego ideal. They are excessive in the case of manic-depressive illness in that once a frustrating or lost object has been reestablished by identification in the ego, it is then tormented by

the cruel severity of the ego ideal, against which, in turn, the ego rebels. The manic phase represents a triumphant reunion between ego and ego ideal, in the sense of expansive self-inflation, but not in the sense of a stabilized equilibrium.

Abraham (1924) in "A Short Study of the Development of the Libido," and "The Influence of Oral Eroticism on Character Formation," pursued his interest in biological development and tried to find specific fixation points for mental illnesses in different phases of libido development. He subdivided the oral phase of libido development into two phases; in the first, sucking impulses predominated and in the second, biting impulses. In the anal phase, he differentiated a period of expelling impulses from a period of retention pleasure. Abraham interpreted the character traits of the normal and diseased individual as highly symbolized derivatives of pregenital instinctual impulses that were hampered in their normal development by frustration or overindulgence. Because of Abraham's influence, psychoanalytic research in ego development has for a long time been dependent on the highly schematized concepts of libido development and its symbolizations. Abraham located the fixation to which the manic depressive periodically regresses as being at the end of the second biting oral phase and the beginning of the first expelling anal phase. This assumption could explain the frequent preoccupation of the manic depressive with cannibalistic phantasies, the

character trends of impatience, of envy and exploitativeness, of dominating possessiveness, of exaggerated optimism or pessimism, the intense ambivalence, the explosive riddance reactions, the phantasies of incorporation in the form of coprophagia or necrophagia. In 1923, G. Roheim had described a custom of mourning in a primitive tribe, in which the mourning ends in a celebration and in the defecation of the mourners on the grave of the deceased. Abraham compared the regression in dementia praecox with its narcissistic pregenitality and withdrawal of libido from reality, which is endured with blunted resignation, to the regression of the melancholic who frequently complains about the loss vociferously and struggles, with signs of most painful ambivalence, to reincorporate the lost or devalued object. The object loss that precedes the onset of a depression is mostly not conscious but, according to Abraham, repeats a primal depression, a frustration at the time of transition from the oral to the anal phase, which means that the child is disappointed in the mother. In addition, the oral dependence may be constitutionally overemphasized. In a manic depressive case history presented by Abraham, the child turns his libido from mother to father--symbolically speaking, from mother's breast to father's penis--and is similarly defeated. The child feels therewith completely forsaken before the stage of the Oedipus conflict has been reached. The castration threat is projected mainly onto the mother, and the frustrated child engages

in oral- and analsadistic phantasies of revenge against both parents. The incorporation of the frustrating parents in the superego leads to self-accusation; their incorporation in the ego makes them a target of inner retaliation.

S. Rado in "The Problem of Melancholia" (1927), went a step further in the theory of identification. Freud's and Abraham's theories imply an incorporation of the lost or frustrating object, in both the tormented ego and the punishing ego-ideal or superego. This double incorporation, Rado postulated, corresponds to an ambivalent splitting into a "good"--that is, gratifying, object-- and a "bad" or frustrating object; at a stage of early development, when the synthetic function of the ego is still weak, both of these are the mother. The good parent by whom the child wants to be loved is incorporated in the superego, endowed with the privilege of punishing the bad parent who is incorporated in the ego. This bad object in the ego is punished to the point of total destruction (suicide). But the ultimate goal of this raging orgy of self-torture is expiation, reconciliation, synthesis. F. Alexander in "Psychoanalysis of the Total Personality" (1930), has elaborated on how the superego can be bribed by self-punishment. Rado describes the manic phase as an unstable reconciliation reached on the basis of denial of guilt. The automatized cycle of guilt, expiation, and reconciliation is patterned after the sequence of infantile, oral experience: rage, hunger, drinking. The drinking, which

resembles the state of reunion or reconciliation, culminates in a satiated pleasure experience, which Rado calls the "alimentary orgasm." In "The Psychoanalysis of Pharmacothymia" (1933), Rado describes how the drug addict, in the artificially produced intoxication, expresses the same yearning for reconciliation and blissful reunion with the gratifying mother.

In the same year, 1933, Helene Deutsch, in her paper, "Psychology of Manic-Depressive States, Particularly of Chronic Hypomanics," illustrated the theory of manic-depressive psychoses, as developed up to that time, by several abbreviated case presentations. She agreed with Rado that the melancholic phase is sometimes introduced by a phase of rebellion of the ego against the cruel superego. After the ego succumbs to the superego's punishment with the unconscious intention of bribing the superego and of gaining forgiveness by such submission, the ego may rescue itself from the dangerous introjection by projecting the threatening enemy onto the outside world; aggression can then be directed against the projected superego, which has become an external persecutor. Another form of escape from the melancholic predicament is the denial of any narcissistic deprivation--be it the loss of mother's breast or the absence of a penis--in a glorious triumph of manic or hypomanic excitement. Helene Deutsch regards mania and paranoia as alternative defenses against the intense danger to survival of an ego oppressed by melancholia. In the

hypomanic patient, the underlying depression had to be lifted into consciousness, to make therapy successful. In 1938, Gertrud Jacob made a similar observation on a periodically manic patient.

George Gero illustrated "The Construction of Depression" (1936) by two case presentations, a woman patient with obsessional character structure and a male patient with apathetic withdrawal in the free intervals. The masochistic deterioration of genitality in the woman patient was not brought about, as in Helene Deutsch's case, by the discovery of the lack of a penis, but by the gloomy, loveless, and joyless atmosphere of the parental home, in which masturbation threats fostered a bloody, terroristic concept of sexuality, and made the child lonely, greedy, and hopeless about successful gratification. This patient built up the obsessional character structure as a defense against the painful ambivalence in her family relations. Only after these character defenses yielded to analysis could this patient see avenues of realistic satisfactions and thereby surmount her depressions. Gero's male patient had identified with an overambitious, overexacting father, and a rejecting mother. The patient had repressed the rage against both frustrating parents by withdrawal into an apathetic regression, punishing therewith the internalized objects of his hate and rage. After his father's death, he had himself changed into a sick old man. The liberation of rage and hate in the transference freed the genital aggressiveness from the odium and guilt of sadomasochistic distortions. In both cases the analyst succeeded

in winning the patients back from a hopeless negativism to a hopeful confirmation of life.

Edith Jacobson has described in "Depression, the Oedipus Complex in the Development of Depressive Mechanisms" (1943), a severely depressed patient, with strong suicidal urges, intense experiences of depersonalization and "Weltuntergang" phantasies—a case on the borderline between manic-depressive psychosis and schizophrenia. Jacobson was able to uncover a primal depression in this patient at the age of three-and-a-half, when the birth of a brother coincided with a disruption of the parental marital relation. Turning from mother to father and back to mother left the patient empty. Threatened by complete loss of objects, she maintained a masochistic dependence on mother. As substitutes for the disappointing parents, she built up phantasies of idealized, perfect parents who endowed her superego with cruel severity, so that she lived in constant danger of complete desertion and in horror of punishment.

Edoardo Weiss in "Clinical Aspects of Depression" (1944), pursued a slightly different approach. He postulated that melancholic episodes are a reaction to the realization of antisocial, dishonest, or egotistical aspects of the personality. The inability of the patient to reach an integration between his antisocial wishes and his moral standards

causes a tension in his "ego feeling" (the cathexis unity of the ego, according to Paul Federn.) The patient hates himself. The exaggerated guilt reaction maintains the split between persecuting and persecuted "introjects." Identifications with hated objects may make the task of ego integration very difficult indeed. In the manic phase, the passive objectionable introject is projected, and the ego assumes the active role of the persecuting superego against objects of condemnation in the outside world. In paranoia, the ego does not cling strongly to the superego, and the persecuting introject, the superego, is projected; in mania, however, the persecuted introject is projected. The paranoic, by this projection, succeeds in preserving his narcissistic position, while the melancholic fails; the result of his inner persecution may be self-destruction. In schizophrenia the splitting processes do not occur along the structural lines of demarcation between id-ego and super-ego, but they are anarchic because of a regression to an earlier stage of incompatible states of identification.

Edvard Bibring in "The Problem of Depression" (1952), collects all the features that different kinds of depression have in common, including not only the depressions of circular psychosis, but also the reactive depressions, depressions in the course of physical illness and in the states of fatigue or exhaustion. A common factor is the lowering

of self-esteem, the loss of self-love, which, in melancholia, is intensified into self-hate. Bibring compares depression with states of depersonalization and boredom. In the mildly depressed person, there is not so much hate turned against the self as there is an exhaustion of the narcissistic supply of self-love. The mildly depressed person does not so much tend to kill himself as to let himself die.

Richard L. Frank in a lecture on "The Defensive Aspects of Depression" (1952), follows a line of thought similar to Bibring's. He compares unspecific depressions to the hibernation of animals-- a defensive response to frustrating life conditions. Depression as a defense tunes down the desires and expectations to a lower key, so that the shock of unavoidable frustration is reduced to a minimum.

The manic aspect of the manic-depressive psychosis has on the whole elicited less attention on the part of psychoanalysts, probably because the manic patient does not so frequently seek therapeutic help, unless he has to be hospitalized. In 1950 Bertram Lewin wrote a monograph on "The Psychoanalysis of Elation." He regards elation as a defense of denial against depression. During the analytic process, normal mourning increases insight into the self and may terminate in a sense of heightened well-being, increased sexual potency, and capacity for work and sublimation. But intellectual insight without emotional self-commitment, without normal mourning, provokes elation or

depression. Both resist the testing of reality. They produce negative therapeutic reactions in the face of insight that cannot at the time be emotionally assimilated. The depressed and the elated ego are not trying to separate the true from the false, but the good from the bad. Reality-testing is replaced by morality-testing. Lewin compares mania to sleep. In sleep the ego disappears; in mania the superego vanishes. Sleep stems from oral satisfaction. The infant drops asleep when he is satiated with nursing at the mother's breast. The dreamless sleep of the satiated child reestablishes the blissful union with the mother at nursing. But only the "benign stupor" (G. Kirby, A. Hoch and J. T. MacCurdy) reproduces the infant's sound and dreamless sleep. The manic patient is a notoriously poor sleeper. His flight of ideas and the plethora of manifest action and speed resemble the anxious, haunting dreams that dispel the sleep. The manic patient is haunted by "the triad of oral wishes," of devouring, being devoured, and wanting to sleep. The first elements of this triad, particularly the wish-fear to be swallowed and devoured transforms the wish to sleep into a fear of dying. The yearning for the gratifying maternal breast--the wish to sleep--may be transmuted into a desire for union with the superego. In the artist this union is accomplished, as a result of the inspiration and the actualization of this inspiration in the creative process, which satisfies both the superego and the world of his contemporaries. In

this connection, it is interesting to read John Custance's Wisdom, Madness and Folly, which gives the "philosophy of a lunatic" who himself suffered from a manic-depressive psychosis. The author guides his reader through the "universe of horror" which unfolds itself to the depressed patient in the visions of eternal punishment, hopeless isolation, panic, self-loathing, and world rejection. But the reader also accompanies the author through his "universe of bliss," when the patient in his manic phase experiences intensified sense impressions, flight of associative ideas, breach of individual barriers, release of sexual and moral tensions and a sense of wish fulfillment in grandeur and world-embracing revelation.

The religious person achieves peace in the ineffable, wordless bliss of union with the Godhead--nirvana, enthusiasm, ecstasis. The drug addict tries to accomplish an artificial relaxation and elation based on the incorporation of intoxicating drugs. The happy mood of elation denies the empirical and acquired knowledge of reality and replaces it by phantasies that contradict frustrations and deprivations. These phantasies carry with them a happy certainty--the repetition of the subjective experience of having been nursed.

Early Parent-Child Relationships

Since all authors who have studied depressive and manic syndromes point to a primal depression or serious disturbances in the early parent-

child relation, we have been interested in learning what the child psychoanalysts have to say about their direct observations of children. Rene A. Spitz's observations as reported in his papers entitled "Anaclitic Depression" (1946) and "Depression--A Psychological Disturbance of the General Adaptation Syndrome" (1952) are interesting in this connection. Spitz called an anaclitic depression the state of dullness, unresponsiveness, and arrest of emotional development that can be observed in babies removed from their mothers' care and left in a hospital. The anaclitic depression is due to an interruption in the baby's dependence relation with his mother. In this state Spitz observed tension, anxieties, excitement, increased autoerotic activities, increased demandingness toward the environment--compensatory efforts in the sense of Hans Selye's general adaptation syndrome. When the deprivation does not last more than three months, the changes of anaclitic depression remain reversible, and the baby recovers when emotional needs are again met. When the deprivation lasts longer, however, irreversible changes take place, permanent physical and psychological damage occurs; the adaptation breaks down; there is arrest of appetite and sleep, loss of weight, morbidity, decreased motility, and facial rigidity, excitement changes into depression, learning is arrested, and autoerotic activities disappear. Social responsiveness, demandingness toward the environment, is the last of the compensatory

efforts to disappear. Indeed the life of the baby who suffers from hospital marasmus is seriously endangered.

Melanie Klein in "A Contribution to the Psychogenesis of Manic-Depressive States" (1935), and in "Mourning and Its Relation to Manic-Depressive States" (1940), has drawn conclusions from her observation of children in the early verbal stages and applied them to the understanding of the psychoses. Her theories deviate in some ways from Freud's theories. In order to understand her deviations, one must go back to Freud's last reformulation of the instinct theory with its postulation of the death instinct, which is the cornerstone of Klein's theories. Many other psychoanalysts have maintained a certain reserve in relation to this concept; Freud himself, with a certain caution, has called the instinct theory "our mythology," and the instincts "mythological beings grandiose in their indefiniteness." Psychological findings never reveal the instincts in pure form; they are deduced from behavior, actions, and emotions. Derivatives of the life and death instincts are never isolated from each other. The two instincts are always in a state of fusion, be it in the pursuit of self-preservation or in the pursuit of supra-individual units, all of which are forms of object relations. Eros, the life instinct, is the force that binds; the death instinct tends to break up the unity of the organism, to reduce it to its inorganic state (Freud's primary masochism). The death instinct also tends to break up the supra-individual units--the interpersonal

relations. If destructive impulses pursue the goal of self-defense or group defense, they remain subordinated to the life instinct. But when the synthetic function of the ego relaxes under the pressure of external or internal dangers, leading to regression with dissociation, a defusion of instincts takes place; for instance, in the regression to the sado-masochistic level, uncontrollable destructive action in its ultimate form of suicide or homicide may overwhelm the binding forces of the life instinct. One would expect the danger signal of anxiety at the moment of defusion of instincts, since the organism's survival is knowingly, or unknowingly, threatened at that time. Anxiety mobilizes increased efforts of the life instinct to reach a higher level of adaptation in order to surmount the danger; but this leads to a breakdown of the synthetic function and to regression and disorganization if the derivatives of the death instinct for external or internal reasons prove stronger than the synthetic function of the life instinct.

Melanie Klein assumes that the fear of death and an automatic reaction to any danger that threatens the survival of the organism is innate in the infant. Freud did not have the same opinion, however; in Inhibitions, Symptoms and Anxiety (1926), he said: "In the unconscious there is nothing which could give contents to our concept of annihilation of life. . . . Something similar to death has never been experienced." He points out,

however, that castration can be imagined on the basis of the daily experience of separation from the intestinal contents and of the loss of the maternal breast at the time of weaning. Thus Freud maintains that the fear of death has to be conceived as an analogue of castration anxiety, which has the meaning of separation from the superego with its power to grant security against all dangers. In Freud's theory, castration anxiety and the superego reach their full development at the stage of the Oedipus conflict, when the child is three to six years old; this leaves the period before the Oedipus conflict to a certain extent uncharted. Melanie Klein has filled this gap by observation of babies and by her empathic understanding of children with whom she has worked therapeutically in the early verbal stage (The Psychoanalysis of Children, 1932). In contrast to Freud, she assumes that the infant from birth on is never merely autoerotically or narcissistically oriented, and that from the start of the extra-uterine existence, there are object relations of an introjective, projective type, while the ego boundaries are still very fluid. The ego is built up on early introjection; but since the synthetic function of the ego is still weak, the infant is endangered by disruptive projections and disintegration, indicated by his readiness for the alarm reaction of anxiety. According to Klein, these early months of labile integration contain the fixation points to which the psychotic individual regresses under stress and strain.

Constitutional weakness in the synthetic function of the ego permits such regression even under lesser degrees of stress. Klein calls these fixation points the "Paranoid" and the "depressive position." That does not mean that the infant passes through the major psychoses, but that the potentialities of psychotic disintegration are implied in the early ego weakness. The paranoid position develops first as automatic defense against pain or displeasure in the form of projection. In the earliest phase when the infant's behavior is centered around the oral zone, swallowing and spitting are his main life-preserving activities. They are accompanied by a reflexive discrimination between pleasure and displeasure. The pleasurable object is automatically incorporated, the unpleasurable spat out, eliminated. The infantile organism tends to maintain automatically a "purified pleasure ego" by splitting pleasure and pain; H. S. Sullivan has called this me and not-me since pleasure is incorporated as me, displeasure ejected as not-me. The not-me--the strange, the unfamiliar, and the uncanny--elicits in the infant the response of dread even in the first weeks of life. Since he recoils from strange objects with signs of horror, Klein has defined the ejected not-me as "bad," the persecutor, and has called the infant's dread-reaction, "persecutory anxiety."

The "depressive position" develops at about the time of weaning (around the first half year of life) when the mother is first recognized

as one person, whether she is at the moment gratifying or depriving, "good" or "bad." This marks the beginnings of recall and foresight in the baby. Even if the mother is absent at a given moment, or does not feed or care for the child satisfactorily, there is no longer the desperate quality of "never again," nor complete desertion; and there is some hope and trust in her return. This hope and trust is based, according to Klein, on the internalization of good experience, "internal good objects." But the beginning durability of the ego and its relation to the object is constantly endangered by the automatic spitting processes "good mother - bad mother" and "good me - bad me." Only the gratifying, good mother elicits good feelings of fulfillment and the good internal object makes the gratified child feel good himself. But an excess of bad experience with a frustrating mother makes the child hateful, enraged, bad, and fills him with bad, emotional content that he tries to get rid of by elimination or denial. The bad, internal object threatens the good internal object with destruction. In this inner conflict, which characterizes the depressive position, Klein sees the first guilt feelings arise as predecessors of what is subsequently conscience or superego formation. Because of the synthetic function of the ego, the dependence on the mother as a whole person so needed for survival and the guilty anxiety prompt the child into repair actions, magically designed to transform the bad mother into a good mother, to protect the good inner object against the onslaught of the

bad one. One is here reminded of the words of Orestes after he had murdered his mother: "Save me, ye Gods, and save your image in my soul." (Goethe's Iphigenie auf Tauris.) The guilty anxiety uses the magic of self-punishment, excessive crying spells, and rage directed against the child's own body.

This depressive position is constantly in danger of being reversed into the earlier "paranoid position," in which the infant was solely dominated by the urge to rid himself of bad inner and outer objects by projection or by manic denial and usurpation of self-sufficient omnipotence. Thus the depressive position is still dominated by the all-or-none principle. The good mother on whom the child depends for survival is idealized into perfection without blemish; and the bad mother appears disproportionately dreadful because of the child's helpless dependency. Only gradually these contrasts are melted into the unity of one realistic mother. Warm consistency on the part of both parents supports this natural process of integration. But parental incompetence, overindulgence, or excessive deprivations, as well as the child's constitutional oversensitivity or intensity of drives, his physical illness, and external pressures--such as a new pregnancy or hostile envy on the part of older siblings--might interfere with the secure harmony which guarantees the optimum in the child's integration with the family. Disrupting, disintegrating experiences are, according to Klein, accompanied by psychotic fears of phantasic proportions, since the lack

of grasp on reality in the young child delivers him as a helpless victim to uncanny powers; this is reflected in his early nightmares, his later fairy tales, his animal phobias and other phobias.

Many psychoanalysts have expressed doubts about Klein's observations on Oedipus experiences in the course of the first year of life. But there is much agreement with Klein's theory that there is no period of narcissistic self-sufficiency, that the infant is object-related from the start by introjection and projection, and that his claim for exclusive appropriation of his love object which guarantees his security in a world of unknown dangers makes him intensely anxious when he witnesses any intimacy between the parents that excludes him. Such intimacies jeopardize his equilibrium and elicit rage reactions which, in turn, are intensely alarming to the child because of his anxious cannibalistic destructiveness. In such early stages of Oedipus conflict as Klein sees it, the destructive possessiveness and not the incestuous wishes give rise to guilty anxiety. The incest wish is a derivative of the binding, reconciling Eros.

According to Klein, paranoid and depressive anxieties in early childhood are closely related. The more primitive persecutory anxiety is solely centered around the preservation of the ego, the object remains a partial object, incorporated as far as it is "good," that is, gratifying; but it is eliminated, projected and therewith experienced as persecutor

as far as it is frustrating, that is, "bad." The later depressive anxiety is centered around the need to preserve the good object as a whole person, and it indicates a broadening of the child's horizon. The badness of his love object in this position spells to the child his own badness on the basis of introjection. The depressive anxiety is a guilty anxiety, coupled with the need to preserve the good object, with the tendency to make amends, to achieve magic repair. This tendency to repair, to make amends, stands in the service of the synthetic function of the ego. When separation anxieties can be surmounted, when repair succeeds, it contributes to a broadening integration of the child's ego and to a more realistic cementing of his labile object relations. Successful repair actions are the basis of sublimation--of all those creative activities by which the growing individual maintains his own wholeness and his hopeful, trusting, integrative relations to his objects. One can say that without the stimulus of depressive anxieties, the child would never outgrow his early egocentricity, his fearful withdrawal, and his tendencies toward hostile projections. But an excess of depressive anxieties without successful experience of repair produces a fixation to the depressive position. It is this position to which the adult regresses whenever frustrating life experiences tax his integrative functions to such a degree that a creative conflict solution appears impossible. The manic reaction presents itself in this context as a pseudo-repair action, since a reconciliation with frustrating objects or goals is

manipulated by the manic with the inadequate means of primitive defense--the splitting of good and bad, the phantastic idealization of the goal or object to be reached, and the hasty incorporation and contemptuous denial of the negative, frustrating aspect of the object or goal.

This survey of Klein's theories represents an analysis of only the particular part of her thinking which is contributory to an interpretation of manic-depressive psychosis. Although Klein's theories are partially deviant from psychoanalytic theory and may even sound fantastic to the psychiatrist who is reluctant to engage in any speculation on what is going on in the preverbal child, one cannot entirely dismiss her empathic understanding of infantile emotions, impulses, and phantasies, which in the child's early verbal phase are expressed symbolically in his play. Her intuitive understanding is at least a working hypothesis for explaining the similarities between infantile and psychotic states of mind. The latter may seem enigmatic because of this very regression to early patterns of unsuccessful integration.

In his more recent work on manic-depressive psychoses, "Psychosomatics of Depression from the Etiologic Point of View," Rado, too, sees depression as a process of miscarried repair, although Rado is quite disinclined to engage in speculations. He strives to make psychoanalytic terminology understandable to scientists in related disciplines whose collaboration we need. The depressive phase, he says, has a hidden

pattern of meaning, and the observer must penetrate into the "unconscious" - "nonreporting" parts of the patient's experience. The depressive spell is a desperate cry for love precipitated by loss of emotional or material security, an expiatory process of self-punishment, to reconcile and regain the aim-image of the gratifying mother's breast. The intended repair miscarries, because the dominant motivation of repentance is complicated by strong resentment. The depressed person wants to force his object to love him. The love-hungry patient's coercive rage has oral, biting, and devouring features. Fasting--the earliest and most enduring form of expiation--springs from the fear of having destroyed mother forever. Rado thinks that coercive rage increases self-esteem and pride, but repentance makes the ego feel weak. Merciless rage, turned against the self, complicates repentance, since the absurdity of self-reproaches betrays the rage against the lost object. The patient is torn between coercive rage and submissive fear. If rage dominates, there is an agitated depression; if fear and guilt prevail, we have retarded depression. These opposite tensions compete for discharge. The phenomenon of "discharge-interference" leads to an interminable struggle. In paranoid patterns, the environment-directed rage dominates, and there is proneness to violence. In therapy the physician may be inclined to treat the patient with overwhelming kindness to meet the patient's craving for affection. But when guilty fear and retroflected rage are alarming in the sense of suicide danger, harsh

treatment may provoke a relieving outburst of rage. Thus Rado points to many unanswered questions concerning the manic-depressive illness.

We have tried to go through the psychoanalytic literature as far as manic-depressive illness is concerned. In spite of some divergencies among the authors here covered, there is agreement that the manic-depressive psychosis represents regression to an early dependent state of development but to a less primitive stage than that of the schizophrenic.

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III. FAMILY BACKGROUND AND CHARACTER STRUCTURE

Family Background.

For all of the twelve patients studied, a consistent finding was made in regard to the family's position in its social environment. Each family was set apart from the surrounding milieu by some factor which singled it out as "different." This factor varied widely. In many instances it was membership in a minority group such as the Jews, as in the case of Mr. H. In others it was economic; for example, one patient's family had lost its money and was in a deteriorating social position (Mrs. A.), and in the case of another patient (Mr. R.), the father's illness and alcoholism had put the family in poor economic circumstances and in an anomalous social position. In another case (Miss L.), the difference resulted from the mother's being hospitalized for schizophrenia.

In every case, the patient's family had felt the social difference keenly and had reacted to it with intense concern and with an effort, first, to improve their acceptability in the community by fitting in with "what the neighbors think," and, second, to improve their social prestige by raising the economic level of the family, or by winning some position of prestige or accomplishment. In both of these patterns of striving for a better social position, the children of the family played important roles; they were expected to conform to a high standard of good behavior, the standard being based largely on the parents' concept of what the neighbors

expected. Thus Mr. R's mother was greatly concerned that he politely thank the neighbor for the cookies she gave him and Mr. H's mother threatened him with severe punishment when he misbehaved while out on the street with her. These attitudes on the part of the parents (chiefly the mother) inculcated in the child a strict and conventional concept of good behavior, and also one which was derived from an impersonal authority--"they." The concept seemed to carry with it the connotation of parents whose own standards were but feebly held and poorly conceptualized, but who would be very severe if the child offended "them."

In addition to the depersonalization of authority, the use of the child as an instrument for improving the family's social position again acted as a force devaluing the child as a person in his own right. Not "who you are" but "what you do" became important for parental approval. Getting good grades in school, winning the approval of teachers and other authorities, receiving medals of honor, winning competitions, and being spoken of as a credit to the parents were the values sought by the parents from the child.

In a number of cases, the child who was later to develop a manic-depressive psychosis was selected as the chief carrier of the burden of winning prestige for the family. This could be because the child was the brightest, the best looking, or in some other way the most gifted, or

because he was the oldest, the youngest, or the only son or only daughter.

The necessity for winning prestige was quite frequently inculcated most vigorously by the mother. She was usually the stronger and more determined parent, whereas the father was usually the weakling, the failure who was responsible for the family's poor fortunes. This was not invariably the case; thus one patient's mother had been hospitalized with schizophrenia from the patient's babyhood on. However, in the more typical cases, the mother was an intensely ambitious person, sometimes directly aggressive, at other times concealing her drive beneath a show of martyrdom. She tended to devalue the father and to blame his weakness, lack of ambition, or other fault for the family's ill fortune. This blaming of the father for the family's lack of position is in all likelihood due to the fact that in this culture the father is customarily the carrier of prestige, as well as being due to the peculiarities of the mother's relationship with him. The mother was usually thought of by the child as the moral authority in the family, and his attitude toward her was usually cold and unloving, but fearful and desirous of approval.

The fathers in the cases studied were thought of by their children as weak but lovable. Two fathers were unsuccessful doctors, one an unsuccessful lawyer, one an unsuccessful tailor, another simply a ne'er-do-well, and so on. By and large they earned some kind of a living for

their families and did not desert them but they were considered failures because of their comparative lack of success in relation to the standard the family should have achieved. The fathers usually were dependent on their wives, although they sometimes engaged in rather futile rebellious gestures against the pressures put on them--as when Mr. H's father spent the evenings playing pool and gambling with his men friends instead of at home listening to his wife's nagging. But, on the whole, they apparently accepted the blame visited upon them and thus implied to their children, "do not be like me." The patients, on the whole, loved their fathers much more warmly than their mothers, and often attempted to defend and justify them for their lack of success; but in their very defense of their fathers they demonstrated their acceptance of mother's standards.

Another important contrast in the child's attitude toward his parents was that in his eyes the mother was the reliable one. Thus the child faced the dilemma of finding the unreliable and more-or-less contemptible parent the lovable one, and the reliable, strong parent the disliked one. This pattern was quite consistent in most of the families of these patients, whether the patient was a boy or a girl. The attitude of the mother toward the father also served as a dramatic example of what might happen to the child should he fail to achieve the high goals set by the mother.

Early Development of the Child.

Present-day concepts of the development of personality in infancy and early childhood no longer assume that the infant has no relationships with the people around him until he has reached the age of a year or so. Rather, it is believed that object relations develop from birth on, although it is obvious that early relationships must be quite different in quality from those experienced later on. Much evidence on infantile development in the early postnatal period^{1/} demonstrates that the infant reacts selectively to various attitudes in the mothering one. He thrives in an atmosphere of warmth, relaxation, and tenderness while he experiences digestive disorders, shows a variety of tension disorders, and even may die of marasmus in an atmosphere of tension, anxiety, and physical coldness. Under these circumstances, a vague, chaotic, and somewhat cosmic concept of another person--the mother one--very soon begins to develop, and to this person the infant attributes his feelings of well-being or ill-being; this person is experienced as being extremely powerful.

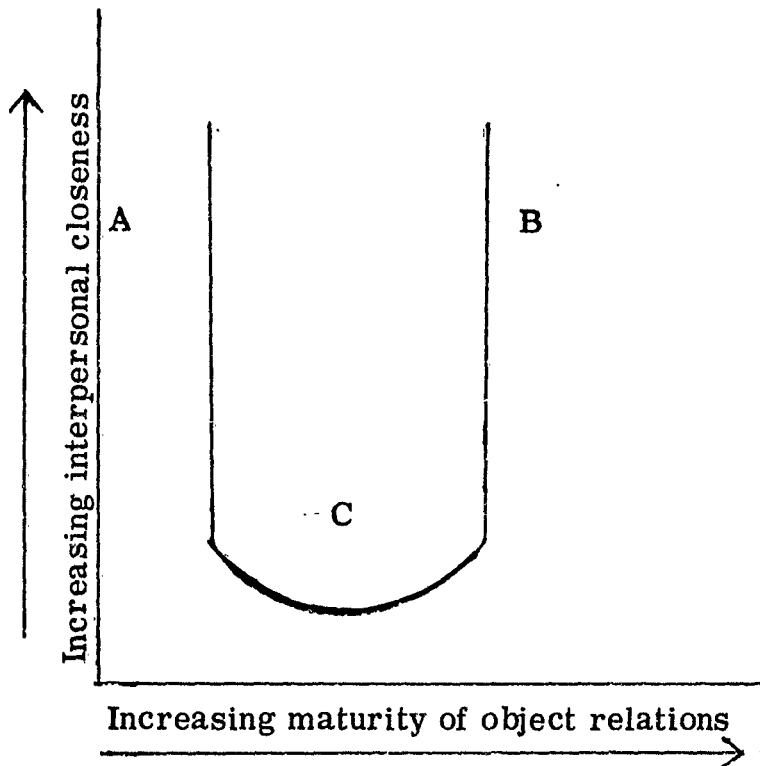
We have compared the reports of the inner experiences of manic-depressives with those given by schizophrenic patients regarding the times of greatest anxiety in each. While it is manifestly impossible

^{1/} See particularly Margaret Ribble, The Rights of Infants; New York, Columbia Univ. Press, 1943.

to make specific constructions on the basis of such accounts, it is nevertheless our impression that they support the conception that the major unresolved anxiety-provoking experiences of the manic-depressive patient occur at a later stage in the development of interpersonal relationships than is the case with the schizophrenic. In the schizophrenic, a conception of self clearly differentiated from the surrounding world does not seem to have been developed, and the patient in panic believes that others are completely aware of his feelings, and that their behavior is undertaken with this knowledge. On the other hand, the manic depressive seems not to experience this breaking down of the distinction between himself and others in times of intense anxiety; rather, he mobilizes defenses which preserve the awareness of self as distinct from others. This formulation has much in common with that of Melanie Klein (see literature section).

The common experience of therapists with the two disorders is to find the manic depressive much more irritating but much less frightening to work with than the schizophrenic. This may be related to the different concepts of self and others that the two groups of patients have.

The following graph represents the difference in interpersonal closeness and object relations between the schizophrenic and the manic-depressive characters.



Points A, B, and C represent successive stages in development.

At and soon after birth (A), other persons (chiefly the mother) are hardly recognized as such, while interpersonal closeness is great but is based upon the intense dependence of the infant upon his mother. As relationships develop, the primary closeness based upon identification diminishes (B). Later, a more mature closeness begins to develop (C), in which the self is at last perceived as distinct and separate from other persons. It is evident that a critical phase in development (point B on the graph) occurs when the closeness with the mother based upon identification has begun to disappear, but the more mature type of relationship based on recognition of others as whole, separate persons has not as yet developed to any great degree.

We conceive of the major, unresolved, anxiety-provoking experiences of the schizophrenic patient as occurring at point A. At this phase of personality development, closeness is based upon identification, and relationships are partial in character. In the manic-depressive patient, these experiences would occur at point B, at a time when identification is less frequently used, but when the ability to relate to others as individuals distinct from one's self is in the earliest stage of development. Consequently although relationships at point B are more mature than at point A, the individual in another sense is in a more isolated position, since he no longer employs the mechanism of identification to the degree that he did in earlier infancy, but has yet to develop the capacity for a higher level of interpersonal relatedness. At this time, therefore, the developing child could be expected to feel peculiarly alone and consequently vulnerable to any threat of abandonment. We would conceive of the neurotic individual as having experienced his major, unresolved anxiety experiences at point C, when interpersonal relatedness is more advanced than at B.

While reliable data about infancy are extremely difficult to gather, our series of manic depressive patients show a preponderance of normal infancies, with one major exception, Mr. R, who was a feeding problem and was malnourished and fretful for the first several months of his life. The mothers of these patients appear to have

found the child more acceptable and lovable as infants than as children, when the manifold problems of training and acculturation became important. Our impression is that it was the utter dependence of the infant which was pleasurable to the mother, and that the growing independence and rebelliousness of the early stage of childhood were threatening to her. Unconforming or unconventional behavior on the part of the child was labelled as "bad" by the mother, and she exerted great pressure to stamp it out. Thus, the heretofore loving and tender mother would rather abruptly change into a harsh and punishing figure, at about the end of the first year. The child, under the stress of anxiety, would have difficulty integrating the early good mother and the later bad mother into a whole human being, now good, now bad. While a similar difficulty in integration may face all children, this split in attitude toward authority, in the more fortunate, is eventually resolved as the personality matures, but it remains with the manic depressive for the rest of his life unless interrupted by life experience or therapy. An important authority is regarded as the source of all good things, provided he is pleased, but as a tyrannical and punishing figure unless placated by good behavior. These early experiences probably lay the groundwork for the manic-depressive's later ambivalence.

Later Development of the Child.

In later childhood, when the child's personality traits and role in the family have begun to crystallize, the manic depressive may be likened to Joseph in the Bible story. Joseph was his father's favorite son. The envy of his eleven brothers was aroused by his father's giving him a multicolored coat, and was increased after they heard of two of Joseph's dreams. The first dream was about eleven sheaves bent down, and one standing upright; everybody knew that this represented Joseph with his eleven brothers bowing to him. In the other dream, eleven stars, the sun, and the moon were bowing to the twelfth star, and everybody agreed that this represented the mother, the father, and the eleven brothers bowing before Joseph. His envious brothers decided to kill him, but one of them, finding himself unable to agree to killing his own flesh and blood, influenced the others to throw him into a pit in the wilderness, and finally to sell him to a passing merchant from a foreign land. After his separation from his family, and his arrival in the foreign land, Joseph immediately grew in stature, and quickly rose to the position of the Pharaoh's first adviser. By his skill and foresight, he averted the evil effects of a threatening famine, not only in Egypt, but also in the neighboring countries.

What is the application of this story to manic-depressive patients?

Many of these patients are the best-endowed members of their families, excelling in some cases in specific creative abilities over their siblings, and over one or both of their parents. Some of them have a special place in the family as a result of their own ambitious strivings as, for example, Mr. H. Others are the favorites of one or both parents for other reasons, sometimes because they are the only one of their sex among the siblings (for example, Mrs. S). All this makes for their enviously guarding the maintenance of their special position in the family group, despite their being burdened with great responsibilities in connection with their special position. It also subjects them to the envy of their siblings, and, quite often, to the competition of one or both parents. Neither the patients themselves nor the family members are, generally speaking, aware of this envy and competition.

As mentioned previously, manic depressives usually come from families who are in minority groups because of their social, economic, ethnic, or religious status. The family members in these minority groups cling together in group-conscious mutual love and acceptance, and in the wish and need to maintain and raise their family prestige in their groups, and their group prestige before an adverse outer world. There is little room for, or concern with, problems of interpersonal relatedness. Under the all-important regime of the maintenance of

prestigious group values, it seldom occurs to any member of these groups to think in terms other than "we belong together." This, then, is a background in which neither the active nor the passive participants in developments of envy and competition are aware of these developments. Yet, without being aware of it, the best-endowed children will spend quite a bit of energy to counteract the envy of the siblings, of which they are uncsciously afraid. Often the children are brought up, not only by their parents, but also by the joint endeavor of several other important older members of the clan. In spite of all this supervision, there is rarely an individual on whom a child can rely with confidence in a one-to-one relationship. In fact, it is frequently the case that the family group has a number of authority figures in it--grandparents, uncles, aunts, and so on--so that the child's experiences of authority are with multiple parent figures. In this setting, the manic depressive in very early childhood is frequently burdened with the family's expectation that he will do better than his parents in the service of the prestige of the family and the clan; consequently, he may feel, or be made to feel, responsible for whatever hardship or failure that may occur in the family. For example, one of our patients (Mrs. A) was held responsible by her sisters for her mother's death when the patient was eighteen months old--"Mother would still be here had you not been born"--for the failure of her father's second marriage, which had been made to

provide a mother for the patient; and for her father's "ruined" feet, the result of tramping the streets as a salesman after his position of considerable prominence had ended in bankruptcy. Another patient (Mr. M) at the age of three felt that he had to take over certain responsibilities toward the clan, sensing that his parents had failed in the fulfillment of these. It should be noted that occasionally the family may be isolated from its social environment because of unusually high prestige, and under these circumstances also the child may develop a manic-depressive psychosis.

In this group-conscious world, the accomplishments of the child are not recognized in their own right, but only as contributions to the prestige needs of the family. This being so, there is not much opportunity for the child to develop clear-cut interpersonal relations or concepts. This situation is aggravated by the fact, mentioned earlier, that the first pathogenic experiences of the manic-depressive patient have interfered with his ability to integrate the mother (and hence other authority figures) into a whole person.

The special role in the family group which these patients hold is additionally cemented by the fact that they are, as a rule, pushed very early into a special role of responsibility, or else themselves assume this role. As a result, their image of the significant people in the family usually differs considerably from that of the other siblings (as in

the case of Mrs. N). With their different appraisal of one or both of their parents, from early childhood they are extremely lonely, in spite of growing up in the group-conscious atmosphere which we have described, where there is little feeling for privacy, and where the little-differentiated experiences of the various family members are considered in the light of the common good of the whole family, or the whole clan (as in the case of Mr. M). In many cases these people are unaware of their loneliness, as long as they are well, because the sentiment of "we belong together" is fostered by their family.

As these people grow up, they remain extremely sensitive to envy and competition. They know what it is like to harbor it themselves and to be its target. One means of counteracting this envy, which early becomes an unconscious pattern, is to undersell themselves to hide the full extent of their qualifications. Another pattern of counteracting active and passive feelings of envy which many of these patients develop is to be helpful to their siblings, to other members of the early group, and, later on, to other people with whom they come in contact in various ways. They often use their talents for promoting other persons and their abilities. The price they unconsciously demand for this is complete acceptance and preference by the others. These traits are repeated in the transference situation during treatment. For instance, a patient was brought to the hospital against her will, without any insight into her mental disturbance. Much to everybody's surprise, she most

willingly entered treatment with one member of our group. Everything seemed to run in a smooth and promising way until suddenly, after about two weeks, the patient declared vehemently that she would continue treatment no longer. When she was asked the reasons, she said that she had been under the impression that she might help her doctor, who was an immigrant, to establish herself professionally in the new country by allowing the doctor to treat her successfully. But during the two weeks she had been at the hospital, she had found that the doctor had already succeeded in establishing herself, and therefore the patient's incentive for treatment was gone.

The Adult Character.

As adults, persons with cyclothymic personalities continue to manifest many of the same traits that they exhibited in childhood. During the "healthy" intervals between attacks, they appear from a superficial point of view to be relatively well adjusted and at ease with other people. A certain social facility is typical of the hypomanic, although it is not seen in the depressive person in his "healthy" intervals. For instance, the hypomanic typically has innumerable acquaintances with whom he appears to be on most cordial terms.¹ On closer scrutiny of these relationships, however, it becomes apparent that they cannot be considered to be in any sense friendships or intimacies. The appearance of closeness is provided by the hypomanic's liveliness,

talkativeness, wittiness, and social aggressiveness. Actually, there is little or no communicative exchange between the hypomanic and any one of his so-called friends. He is carrying out a relatively stereotyped social performance, which takes little or no account of the other person's traits and characteristics, while the other person, quite commonly, is allowing himself to be entertained and manipulated.

Both the hypomanic and the depressive share in their tendency to have one or a very few extremely dependent relationships. In the hypomanic this dependency is concealed under all his hearty good humor and apparent busyness, while it is quite clear in the depressive. The hypomanic or the depressive is extremely demanding toward the person with whom he has a dependent relationship, basing his claim for love and attention upon his need of the other, and making it a quid pro quo for his self-sacrifice. Demands are made for love, attention, service, and possessions. The concept of reciprocity is missing; the needs of the other for similar experiences are not recognized. Yet the failure to recognize the needs of the other does elicit unconscious guilt feelings, which are rationalized by the manic depressive's thinking of himself as having given a great deal. What the giving seems to amount to is a process of underselling himself. In the relationship the devaluation and underselling also indicate to the partner the person's great need of him, and serves to counteract the old, unconscious, fearful expectation of

competition and envy from the important person. The cyclothymic person's own envy and competition, too, are hidden from his awareness, and take the form of feelings of inferiority and great need. The person conceives of himself as reaching success, satisfaction, or glory through the success of the other rather than by efforts of his own. Thus Mr. H made himself the stooge of the president of the class in high school, receiving as his reward the political plums that the president was able to hand out, and failing to recognize that what he actually wanted was to be class president himself. He continued this kind of relationship with some important figure (usually male) in every free period afterward, while in his psychotic attacks the wish to be president himself came to consciousness, and he made futile efforts to achieve it.

Thus, the process of underselling themselves, both for the sake of denying envy and in order to become the recipient of gifts from the other, often reaches the point where these persons actually paralyze the use of their own endowments and creative abilities. They themselves frequently believe that they have lost their assets or that they never had any. The process of underselling themselves, especially in depressives, also may convince other people in their environment of their lack of ability. At this point, they begin to hate these other people for being the cause of the vicious circle in which they are caught; and they hate themselves because they sense the fraudulence of their behavior in not having expressed

openly all their inner feelings. One patient, Mr. M, said time and again during his depression, "I'm a fraud, I'm a fraud; I don't know why, but I'm a fraud." When he was asked why he felt fraudulent, he would produce any number of rationalizations, but at last it was found that the thing he felt to be fraudulent was his underselling of himself. This same patient got so far in his fraudulent attempt at denying his total endowment that he was on the verge of giving up a successful career--which, while he was well, held a good deal of security and satisfaction for him--in order to regain the love of an envious friend, which he felt he was in danger of losing because of his own greater success.

We see then, in the adult cyclothymic, a person who is apparently well adjusted between attacks, although he may show minor mood swings or be chronically overactive or chronically mildly depressed. He is conventionally well-behaved and frequently successful, and he is hard-working and conscientious; indeed, at times his overconscientiousness and scrupulousness lead to his being called obsessional. He is typically involved in one or more relationships of extreme dependence, in which, however, he does not show the obsessional's typical need to control the other person for the sake of power, but instead seeks to control the other person in the sense of swallowing him up. His inner feeling, when he allows himself to

notice it, is one of emptiness and need. He is extremely stereotyped in his attitudes and opinions, tending to take over the opinions of the person in his environment whom he regards as an important authority. Again this contrasts with the outward conformity but subtle rebellion of the obsessional. It should be emphasized that the dependency feelings are largely out of awareness in states of well being and also in the manic phase.

His principal source of anxiety is the fear of abandonment. He is afraid to be alone, and seeks the presence of other people. Abandonment is such a great threat because his relationships with others are based upon utilizing them as possessions or pieces of property. If he offends them, by differing with them or outcompeting them, and they withdraw, he is left inwardly empty, having no conception of inner resources of his own to fall back on. Also, if they offend him and he is compelled to withdraw, this leaves him similarly alone. In this situation of potential abandonment, the anxiety is handled by overlooking the emotional give-and-take between himself and others, so that he is unaware of the other person's feelings toward himself or of his feelings toward the other. This is clearly seen in the well-known difficulty which therapists have in terminating an hour with a depressive. Regardless of what has gone on during the hour, at the end of it the depressive stands in the doorway, plaintively seeking reassurance by some such question

as "Am I making any progress, Doctor?" An attempt to answer the question only leads to another or to a repetition of the same one, for the patient is not seeking an answer, or rather does not actually believe there is an answer, but instead is striving to prolong his contact with the doctor. In carrying out this piece of stereotyped behavior, he is unaware of the fact of the doctor's mounting impatience and irritation, which has the clear consequence that, instead of there being increasing closeness between patient and doctor, a situation has now been set up in which the distance between them is rapidly increasing.

This character structure can be seen to have a clear-cut relationship to the infantile development which we have hypothesized for the manic depressive. According to this hypothesis, interpersonal relations have been arrested in their development at the point where the child recognizes himself as being separate from others, but does not yet see others as being full-sized human beings; rather he sees them as entities who are now good, now bad, and must be manipulated. If this is the case, then the adult's pooriness of discrimination about others is understandable. His life and welfare depend upon the other's goodness, as he sees it, and he is unable to recognize that one and the same person may be accepting today, rejecting tomorrow, and then accepting again on the following day. Nor can he recognize that certain

aspects of his behavior may be acceptable while others are not; instead, he sees relationships as all-or-none propositions. The lack of interest in and ability to deal with interpersonal subtleties is probably also due to the fact that the important persons in the child's environment themselves deal in conventional stereotypes. The child, therefore, has little opportunity at home to acquire skill in this form of communication.

We have said little in this report about the manic depressive's hostility. We feel that it has been considerably overstressed as a dynamic factor in the illness. Certainly, a great deal of the patient's behavior leaves a hostile impression upon those around him, but we feel that the driving motivation in the patient is the one we have stressed--the feeling of need and emptiness. The hostility we would relegate to a secondary position: we see hostile feelings arising in the patient as the result of frustration of his manipulative and exploitative needs. We conceive of such subsequent behavior as demandingness toward the other or self-injury as being an attempt to restore the previous dependent situation. Of course, the demandingness and exploitativeness are exceedingly annoying and anger-provoking to those around the patient--the more so because of the failure of the patient to recognize what sort of people he is dealing with. But we feel that much of the hostility that has been imputed to the patient has been the result of his annoying impact upon others, rather than of a primary motivation to do injury to them.

The Psychotic Attack.

The precipitation of the depressive attack by a loss is well known. However, there have been many cases in which attacks have occurred where there has been no loss. In some it has seemed that a depression occurred at the time of a promotion in job or some other improvement in circumstances. On scrutiny it can be seen that in those patients where a depression has occurred without an apparent change in circumstances of living, the change which has actually occurred has been in the patient's appraisal of the situation. The patient incessantly hopes for and strives for a dependency relationship in which all his needs are met by the other. This hope and the actions taken to achieve it are for the most part out of awareness since recognition of them would subject the person to feelings of guilt and anxiety. After every depressive attack he sets forth upon this quest anew. In the course of time, it becomes apparent to him that his object is not fulfilling his needs: He then gets into a vicious circle; he uses depressive techniques--complaining or whining--to elicit the gratifications he requires. These become offensive to the other who becomes even less gratifying; therefore, the patient redoubles his efforts and receives still less. Finally, he loses hope and enters into the psychotic state where the pattern of emptiness and need is repeated over and over again in the absence of any specific object.

As to the person who becomes depressed after a gain rather than a loss, we interpret this as being experienced by the patient himself as a loss, regardless of how it is evaluated by the outside world. Thus a promotion may remove the patient from a relatively stable dependency relationship with his co-workers or with his boss, and may call upon him to function at a level of self-sufficiency which is impossible for him. Also, being promoted may involve him in a situation of severe anxiety because of the envious feelings which he feels it will elicit in others, the fear occurring as the result of his unresolved childhood pattern of envying those more successful than himself and, in return, expecting and fearing the envy of others at his success. Having made them envious, he may believe that he can no longer rely on them to meet his needs, whereupon he is again abandoned and alone.

The manic attack is similar to the depressive in following a precipitating incident which carries the meaning of a loss of love. It often happens that there is a transient depression before the outbreak of manic behavior. For instance, Mr. H was mildly depressed at Christmas time; his behavior from then on showed increasing evidence of irrationality which, however, was not striking enough to cause alarm until June, when he developed a full-blown manic attack. We believe, from our experience with patients who have had repeated attacks, that the presence of depressive feelings prior to the onset of the manic phase is very common, and perhaps the rule.

It is well known that many manic patients report feelings of depression during their manic phase. As one of our patients put it, "I am crying underneath the laughter." We believe that dynamically the manic behavior can best be understood as a defensive structure utilized by the patient to avoid recognizing and experiencing in awareness his feelings of depression. The timing of the manic behavior varies widely: it may either precede the depression, in which case it can be understood as a defense which has eventually failed to protect the patient from his depression, or it may follow the depressive attack, when it represents an escape from the more unbearable depressive state into something more tolerable. Subjectively, the state of being depressed is one of more intolerable discomfort than the state of being manic, since the patient in effect is threatened with loss of identity of his self.

There are personalities who are able to lead a life of permanent hypomania, with no psychotic episodes. Of course, many chronic hypomanics do have psychotic episodes, but there are some who never have to be hospitalized. Such a patient was Mr. R, who had a very narrow escape from hospitalization when he became agitatedly depressed at a time when several severely anxiety-producing blows occurred in rapid succession. On the whole, however, he maintained what appeared to be an excellent reality adjustment. Subjectively, he was usually constrained to avoid thinking of himself and

his feelings by keeping busy, but when he did turn attention inward, then intense feelings of being in an isolated, unloved and threatened position would arise.

In the light of the above discussion of the manic and depressive attacks, we have come to the conclusion that they need to be differentiated psychodynamically only on the score of what makes the manic defense available to some patients while it is not so usable by others. Some investigators postulate a constitutional or metabolic factor here, but in our opinion adherence to this hypothesis is unjustified in the present state of our knowledge. We feel that further investigation of the manic defense is indicated before a reliable hypothesis can be set up.

We feel that the basic psychotic pattern is the depressive one. The onset of a depression seems understandable enough in the light of the patient's typical object-relation pattern described earlier. That is, getting sick, grief-stricken and helpless is only an exaggeration and intensification of the type of appeal which the manic depressive makes to the important figures in his life in the healthy intervals. When this type of appeal brings rejection, as it usually does when carried beyond a certain degree of intensity, then the vicious circle mentioned earlier can be supposed to set in, with each cycle representing a further descent on the spiral. At the end, the patient is left with his severely depressed feelings and with no feeling of support or

relatedness from the people whom he formerly relied on. At this point, where the feelings of depression and emptiness are acute, the patient may follow one of three courses: He may remain depressed, he may suicide, or he may regress still further to a schizophrenic state.

If he remains depressed, he carries on a chronic, largely fantastic acting-out of the pattern of dependency. There is no longer a suitable object. The members of the family who have hospitalized him are now only present in fantasy. The patient does, however, continue to address his complaints and appeals to them as though they were still present and powerful. In addition, he rather indiscriminately addresses the same appeal to all of those around him in the hospital. The appeal may be mute, acted out by his despair, sleeplessness and inability to eat, or it may be highly vociferous and addressed verbally to all who come in contact with him, in the form of statements about his bowels being blocked up, his insides being empty, his family having been bankrupted or killed, and so on. The same pattern is developed with his therapist: instead of a therapeutic relationship in which he strives to make use of the doctor's skill with some confidence and notion of getting somewhere, the same empty pattern of mourning and hopelessness is set up, in which he strives to gain help by a display of his misery and to receive reassurance by repeatedly requesting it. It is notable and significant that his ability to work on or examine the nature of his relationships is nonexistent; that

difficulties with others are denied and self-blame is substituted. The major therapeutic problem with the depressive is actually the establishment of a working relationship in which problems are examined and discussed. Conversely, the major system of defenses which have to be overcome in order to establish such a working relationship lie in the substitution of the stereotyped complaint or self-accusation for a more meaningful kind of self-awareness. There seems to be a sort of clinging to the hope that the repetition of the pattern will eventually bring fulfillment. Relinquishing the pattern seems to bring with it the danger of suicide on the one hand, or disintegration on the other. It is our opinion that, in the situation in which the patient has given up his habitual depressive pattern of integration and has as yet not developed a substitute pattern which brings some security and satisfaction, he is in danger of suicide. The suicide, as has been well demonstrated by previous workers, has the meaning of a further, highly irrational attempt at relatedness. It can be thought of as the final appeal of helplessness. "When they see how unhappy I really am, they will do something." This fits in with the almost universal fantasy indulged in by most people in moments of frustration and depression of what "they" will say and do when I am dead. Along with this magical use of death to gain one's dependent ends, goes a fantasy of recapturing the early relationship by dying and being born again. On the other hand, self-destruction also has a more rational

element; that is, it is the final expression of the feeling that all hope is lost, and the wish to get rid of the present pain. We are inclined to believe that the element of hopelessness in the act of suicide has not been given sufficient weight in previous studies.

Sullivan, at the end of a great many years of studying the obsessional neurotic, came to the conclusion that many of the more severely ill cases were potentially schizophrenic in situations where their habitual and trusted obsessional defenses proved inadequate to deal with anxiety. This statement also applies to the depressive: If the defensive aspects of the depression become ineffectual, then a collapse of the personality structure can occur with an ensuing reintegration on the basis of a schizophrenic way of life rather than a depressive one.

Guilt and the Superego.

We have avoided using the term superego in this report, and have not involved the cruel, punishing superego in our attempted explanation of the depression. It is our opinion that utilization of the term superego in this way merely conceals the problem rather than explains it. There are several basic questions regarding the problems of conscience and guilt in the manic depressive. First, what influences account for the severe and hypermoral standards of these people? And second, what is the dynamic function of the self-punishing acts and attitudes which are engaged in during the periods of illness?

The overcritical standards of manic depressives are not explicable by a direct taking-over of the standards of the parents, as these patients in childhood have been treated with rather exceptional overindulgence. However, in the section on family background we did mention the peculiar combination of lack of conviction of worth and a standard of behavior in the family coupled with an intense devotion to conventional morality and what other people think. It is logical that a child raised by an inconsistent mother who is at times grossly overindulgent and at others severely rejecting, would be unable to build up a reasonable code of conduct for himself and that his code--focussed around what an impersonal authority is supposed to expect of him and based on no concept of parental reliability or strength--would be both oversevere and frightening in its impersonality. In all probability, much of his moral code is based on the struggle to acquire those qualities of strength and virtue which he finds missing in his parents. Later in this report we will return to the problem of authority in the manic depressive. Suffice it to say here that in dealing with authority this type of patient shows a rigid preconception of what authority expects of him as well as a persistent conviction that he must fit in with these expectations which are beyond the reach of reason or experience. The authority appears, in our experience, at times as an incorporated superego and at other times as a projected, impersonal but tyrannical force. Or

rather, every significant person in the patient's social field is invested with the quality of authority.

In this relationship with authority, the self-punitive acts and experiencing of guilt can be understood as devices for placating the impersonal tyrant. The guilt expressed by the depressive does not carry on to any genuine feeling of regret or effort to change behavior. It is, rather, an end in itself. Merely suffering feelings of guilt is expected to suffice for regaining approval. On the other hand, it may also be seen that achieving a permanent, secure, human relationship with authority is seen as hopeless. Therefore, no effort to change relationships or to integrate on a better level of behavior is undertaken, and the patient merely resorts to the magic of uttering guilty cries to placate authority.

IV. DIFFERENTIAL DIAGNOSIS OF THE MANIC DEPRESSIVE

Some observers have stated that in the intervals between attacks, the manic depressive has a character structure similar to that of the obsessional neurotic. It has also been asserted that in the psychotic phase the manic depressive illness is essentially schizophrenic. This latter statement is supported by the fact that many manic depressives do, in the course of time, evolve into chronic schizophrenic psychoses, usually paranoid in character. In general, there has always been much uncertainty as to who should be diagnosed manic depressive--an uncertainty which is reflected in the widely differing proportions of manic depressives and schizophrenics diagnosed in different mental hospitals.

What, then, is the point of singling out a diagnostic category called manic depressive? In our opinion, the manic-depressive syndrome does represent a fairly clear-cut system of defenses which are sufficiently unique and of sufficient theoretical interest to deserve special study. We feel that equating the manic-depressive character with the obsessional character overlooks the distinguishing differences between the two. The obsessional, while bearing many resemblances to the manic depressive, uses substitutive processes as his chief defense. The manic, on the other hand, uses the previously mentioned lack of interpersonal awareness as his chief defense, together with the defensive processes which are represented by the manic and the depressive symptoms themselves. The

object relations of the obsessional are more stable and well developed than those of the manic depressive. While the obsessional's relations are usually integrations in which there is an intense degree of hostility, control, and envy, they do take into consideration the other person as a person. The manic depressive, on the other hand, develops an intensely dependent, demanding, oral type of relationship which overlooks the particular characteristics and qualities of the other.

According to Sullivan's conceptualization of the schizophrenic process, the psychosis is introduced typically by a state of panic, in which there is an acute break with reality resulting from the upsurge of dissociated drives and motivations which are absolutely unacceptable and invested with unbearable anxiety. Following this acute break, a variety of unsuccessful recovery of defensive processes ensue, which we call paranoid, catatonic, or hebephrenic. These represent attempts of the personality to deal with the conflicts which brought about the panic: the paranoid by projection; the catatonic by rigid control; the hebephrenic by focussing on bodily impulses. According to this conception, the manic depressive can be differentiated from the schizophrenic by the fact that he does not exhibit the acute break with reality which is seen in the schizophrenic panic. On the other hand, his psychotic processes of depression, or of mania, can be thought of as serving a defensive function against the still greater personality disintegration which is represented by

the schizophrenic state. Thus, in persons whose conflicts and anxiety are too severe to be handled by depressive or manic defenses, a schizophrenic breakdown may be the end result.

Contrasting the schizophrenic and the manic depressive from the point of view of their early relationships, we see that the schizophrenic has accepted the "bad mother" as his fate, and his relation to reality is therefore attenuated. He is inclined to withdraw into detachment. He is hypercritical of family and cultural values. He is sensitive and subtle in his criticisms, original but disillusioned. He is disinclined to rely on others and is capable of enduring considerable degrees of loneliness. His reluctance to make demands on the therapist makes the therapist feel more sympathetic, and therefore the therapist is frequently more effective. In addition, the schizophrenic patient is more effective in his aggression; he can take the risk of attacking, for he is less afraid of loneliness. He is more sensitively aware of the emotions of the therapist, since the boundaries between ego and environment are more fluid. The schizophrenic is not inclined to pretend, and is not easily fooled by other people's pretenses. Dream and fantasy life are nearer to awareness, and guilt feelings are also more conscious than unconscious.

The typical manic depressive, on the other hand, has not accepted the "bad mother" as his fate. He vacillates between phases in which he fights with the bad mother, and phases in which he feels reunited with the

good mother. In the manic phase, his relationship with reality is more tenuous; he shows a lack of respect for other people, and all reality considerations are dismissed for the sake of magic manipulation to make the bad mother over into a good mother. The manic depressive is, therefore, mostly a good manipulator, a salesman, a bargaining personality. He is under-critical instead of being hypercritical. He easily sells out his convictions and his originality in order to force others to love him, deriving from this a borrowed esteem. In the depressive phase, he sacrifices himself to gain a good mother or to transform the bad mother into a good one. In order to do this, he calls himself bad, and suffers to to expiate his sins. But these guilt feelings are, in a sense, artificial or expedient, utilized in order to manipulate the bad mother into becoming a good mother. The depressive does not come to terms with realistic guilt feelings. Instead, he uses his self-accusations, which frequently sound hypocritical, to convince the mother or a substitute that his need to be loved has absolute urgency. He denies his originality because he is terribly afraid of aloneness. He is more of a follower than a leader. He is dependent on prestige, and is quite unable to see through the pretense of his own or other people's conventionalities. He shows a high degree of anxiety when his manipulations fail. His denial of originality leads to feelings of emptiness and envy. His lack of subtlety in interpersonal relationships is due to his overruling preoccupation with exploiting the

other person in order to fill his emptiness. This operates as a vicious circle: He has to maintain his claims for the good fulfilling mother, but his search for fullness via manipulation of another makes him feel helpless and empty. This incorporation of another person for the purpose of filling an inward emptiness, of acquiring a borrowed self-esteem, is very different from the lack of ego boundaries in the schizophrenic. The schizophrenic is in danger of losing his ego, and he expresses this danger in fantasies of world catastrophe. The manic depressive is threatened by object loss, since he habitually uses the object to patch up his ego weakness. Object relations in the manic depressive are, therefore, clouded by illusions, but even when he wails, demands, and blames the frustrating object, he is--by this very agitated activity in behalf of his own salvation, ineffective as it may be--defended against the loss of the ego. When the manic depressive becomes schizophrenic, this defense breaks down.

It should be noted that the infantile dependency and manipulative exploitativeness seen in the manic depressive are not unique to this type of disorder. They occur, in fact, in many forms of severe mental illness. The hysteric, for instance, exemplifies infantile dependency and exploitativeness as dramatically as the manic depressive. However, the combination of these traits with the other outstanding characteristics of the cyclothymic personality--particularly the communicative defect and the accompanying inability to recognize other persons as anything but good-bad stereotypes and

the conventional but hypermoralistic values--does become sufficiently distinct and unique to distinguish these patients characterologically from other types.

V. PROBLEMS IN THERAPY; TRANSFERENCE AND COUNTERTRANSFERENCE

Transference

The diagnosis of manic-depressive character has, in the past, been made largely on the basis of the patient's exhibiting the classic manic and depressive symptomatology. It can, however, be as validly made on the basis of the transference-countertransference pattern, which is set up between the patient and the therapist. The transference pattern is particularly characteristic; the countertransference pattern would, of course, vary considerably according to the character of the therapist, although it, too, shows a number of quite typical features.

The transference pattern shows two outstanding characteristics which could be labeled (1) the exploitative clinging dependency, and (2) the stereotyped approach to other persons, who are not seen as personalities in their own right.

(1) The dependency: Other workers in the field of the study of manic-depressive illnesses have amply documented the deep-seated dependency of this type of person (Abraham, Freud, Rado, Klein). The dependency attitudes toward the object are highly ambivalent. Gratification is demanded, but not accepted or experienced as such, and the patient feels that attention, care, and tenderness must be forced from the other person. The force applied is that of demonstrating to the other person how miserable he is making one, how much the depressed one needs the other, and how responsible and culpable the

other is if he fails to meet the depressive's needs. The demands are not directly verbalized but rather consist of a wordless exploitation; the reactive hostility is not experienced as such, but instead is experienced as depression.

In the depths of the depression, it seems impossible to satisfy the patient's dependency needs. As one therapist put it, the patient seems to be saying, "I am starving, and I won't get what I need." The amount of time and attention the patient receives does not suffice to give him a sense of satisfaction. He remains depressed, crying out for more. We have not tried the experiment of spending the major portion of each day with a depressive person. Certainly twenty-four-hour-a-day nursing does not suffice to give the patient a sense of gratification. Whether unlimited time from a therapist would have more effect is debatable, in the light of our experience with Mr. R, which will be discussed in more detail in the section on therapy. This type of demandingness is typical of the depressive aspects of the illness. When the patient is in a period of relative mental health, these needs are less apparent. This raises the question of what becomes of these needs during such periods: Are they not present and only stirred up again when some unusual deprivation or threat to security occurs, or are they successfully kept in repression during the healthy phases? We have commented on this question in Part III, in the section on the Adult Character.

In the manic phase, the demandingness is much more open but is seen by the patient as demanding his rights rather than as asking for favors. Rejection of the demands is met with overt hostility rather than with a depressive response. The manic, of course, shows, in addition to the demandingness, the tendency to take what he needs by force, if necessary, and he will use direct aggression--in contrast to the depressive, who uses reproaches against the other person as a forcing maneuver.

(2) The stereotyped response: The manic-depressive personality shows a highly characteristic tendency to look upon others as stereotyped repetitions of parental figures. This has been described elsewhere in this report as "a lack of interpersonal sensitivity." The therapist is regarded (a) as an object to be manipulated for purposes of getting sympathy and reassurance, (b) as a moral authority who can be manipulated into giving approval, and (c) as, in actuality, a critical and rejecting superego figure who will not give real approval but can be counted on only for token approval which can be achieved by proper behavior or manipulation. This uncritical categorization of the therapist results in the patient's inability to use the therapist to provide himself with a fresh point of view. Everything that the therapist says is reworked into the old pattern of concealed disapproval covered over with the sugar of artificial reassurance. This impenetrability to the

reception of new ideas from the therapist represents one of the great obstacles in therapy with this type of patient, who will give lip service to the role of the therapist as a noncritical authority without a feeling of conviction that this is so. However, lip service itself then becomes incorporated into the set of manipulative acts which will receive approval and adds another bulwark to the defense.

Early in the study of these patients, it was felt that the lack of ability to appraise the therapist as a person represented a real learning defect in the patient and that one of the therapeutic tasks therefore was a somewhat educational one of showing the patient how one person could be different from another. On further study we have come to the conclusion that the defect is not an educational one, evidence for this being that as the anxiety diminishes in an interpersonal relation, the sensitivity increases. Mr. R. is an excellent illustration of this point. His therapist spoke of him as follows: "When the patient first entered treatment, I would have described him as being without the ability to empathize with another. During the subsequent years of treatment, it became apparent that the patient was acutely sensitive to nuances in the attitude of others to him, but that his interpretation of these attitudes was extremely static and stereotyped. Finally, at the end of treatment, he retained much of his sensitivity but had also gained in his ability to respond with accuracy in interpersonal situations. Mr. R's sensitivity

is illustrated by the following incident: He wished to make a change in his Army assignment. The therapist was, he believed, in a position to use her influence to get him the new assignment. He did not ask the therapist to use her influence except by implication; that is, he wrote a letter stating what his plans were about getting the new assignment, and, reading between the lines, it became apparent to the therapist that she was expected to offer to use what influence she had to bring this about. This indirect request was answered indirectly by the therapist with an encouraging letter in which no offer was made to intervene on the patient's behalf. The patient became depressed in a matter of weeks, and when he next saw the therapist, his statement was that the therapist obviously did not approve of his new plans and believed him to be incapable of the change of job which he had wished for. The interpretation was promptly made that these were projections which had been precipitated by his unverbilized request and his unconscious resentment when his request was not met. The patient accepted the interpretation without hesitation and the projected hostile belittling attitudes attributed to the therapist were immediately dropped and the patient's further discussion continued on a more realistic basis.

Another therapist expressed her experience with a patient (Miss T) in the following way: "The discontinuity between what they think and what they act, and the impression of routinization or mimicry which

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Another therapist expressed her experience with a patient (Miss T) in the following way: "The discontinuity between what they think and what they act, and the impression of routinization or mimicry which

goes with them, comes from a dissociation of the function of empathy from the rest of their activity, so that the rest of their activity has lost the significance which comes in with the empathic exchange."

She contrasted this with the schizophrenic: "I think that the schizophrenic has a mature development of the function of empathy, whereas it is rudimentary in the manic depressive. The schizophrenic has had his experiences and utilized them in that realm, and your exchange there is as your exchange would be if it were with any so-called normal person, although it is very much more important in that the individual is more sensitive." Therapeutically, this has the following result: "I enter much more actively myself into emotional relationship with these people [manic depressives] In general, I probably take an excessively neutral posture. . . but I don't do that with these patients. . . . I have in my own mind and in my own feeling that I am talking to the patients not verbally. It [verbal communication] is a means of carrying inflection and of being the accompaniment of facial expression and postural changes. I have the most extraordinary difficulty with depressive patients that at the end of the hour I have the greatest difficulty recollecting what the verbal exchanges have been, because my concentration has not been on the verbal exchanges, but on the empathic exchanges."

In this discussion, the therapist is using the term "empathic exchange" to signify an essentially nonverbal communication of affect or meaning. We have used a variety of descriptive phrases, including "a lack of interpersonal sensitivity" and "the stereotyped response." These two terms attempt to describe the same phenomenon as the therapist is describing in terms of a maldevelopment of the empathic function. The phenomenon is observed by a multitude of therapists but not yet satisfactorily understood, as witness the multiplicity of descriptive phrases. We feel that it is closely related dynamically to the difficulty in object relationships mentioned in Part III, in the Section on Early Development of the Child. There the developmental defect in the child who will later become a manic depressive was described as a failure to integrate the early part-objects into wholes and instead the retention of the concept of a separate good and bad mother. Approaching the problem from the point of view of present-day relationships, we suggest that it is anxiety-arousing for the manic depressive to recognize others as persons as well as to conceive of himself as a person in his own right. It is probable that the intolerable aspect of this is the recognizing of good and bad traits in one and the same person; this requires a certain amount of independence--that is, the ability to deal with the good and put up with the bad. The manic depressive's recognition of bad or unacceptable traits in another person would interfere

with his dependency on him; it would be necessary for him to abandon the other person for his badness, and this would then leave him alone. In order to avoid this anxiety, the manic depressive avoids the recognition and identification of the medley of attractive and unpleasant traits in others, and thereby avoids the exchange of a variety of complex feelings. Thus, as is so often true in psychopathology, what begins as a developmental defect ends up as an anxiety-avoiding defense.

Technical Problems

There are two major technical problems in dealing with the manic-depressive patient which derive logically from the transference picture as developed above. These are the technical problems related to meeting the dependency needs and the technical problems related to breaking through the stereotyped characterization of the therapist.

The dilemma with regard to dependency can be stated as follows:

Attempts to meet the dependency needs and to permit the type of manipulation that the patient characteristically engages in merely support the present way of relating. Our experience has shown us that the assumption of the classical passive and accepting role of the therapist tends to imply to the patient that his dependency needs are being met or will be met. There is, of course, considerable frustration for the patient in the therapist's nonintervention in any active way in the direction of meeting the patient's needs when the classical psychoanalytic

technique is used. However, this does not seem to suffice to interfere with the patient's fantasy that the therapist will be, or can be induced to be, the sort of giving parental figure whom the patient is looking for, and it therefore seems that something more active is needed in terms of a denial by the therapist that he will play the role the patient wishes him to play. The opposite tactic of actively rejecting the patient's demands is equally or even more undesirable, since this then reinforces the patient's belief that he is bad, and tends to push him in the direction of redoubling his efforts to please the harsh authority and thereby receive the blessings of approval, and so on. Furthermore, in both of these types of therapeutic approach, the threat of suicide is an ever present, although perhaps not verbalized, obstacle. In our experience suicide may occur under the following conditions: The patient establishes his characteristic dependency relationship and enters into his characteristic fantasies of gratification. He then experiences something in the relationship which he interprets as a rejection. Following this he becomes hopeless about achieving his goal and then he becomes suicidal. In other words, as long as the patient hopes that he can get the gratification from the object, the danger of suicide is less. Consequently, any therapeutic situation which implicitly promises to the patient that he can get his need gratified is running the risk of the patient's finally discovering the hopelessness of this search and becoming suicidal.

Following these considerations a step further, it seems logical to suppose that a relatively active denial of the role in which the patient casts the therapist must be present from the beginning of treatment. This is extremely difficult to achieve. One of the countertransference difficulties, which will be discussed further, is the fact that the therapist unconsciously frequently falls into a variety of ways of meeting the patient's demands without being fully aware of the fact that he has been manipulated.

The second major technical difficulty--that of breaking through the patient's stereotyped response sufficiently to introduce new concepts to the patient, and to free his own feelings--is not, of course, unique to the treatment of the manic-depressive, although it does represent quantitatively a greater obstacle with these patients. It has become a truism of psychotherapy that a patient with a distorted attitude toward others tends to relate himself to new persons in such a way as to perpetuate his own problem. This process has been named selective inattention by Sullivan. Thus one who believes in his own unlovability will observe and react only to the rejecting elements in the attitude of the people around him, utilizing his observations to continually confirm the "fact" that people don't like him. The rigidity with which such a point of view is maintained varies with the severity of the illness and the strength of the anxiety, and is much more difficult to deal with in the psychoses than in

the neuroses. However, in the manic-depressive, the problem is reinforced by the stereotyped defense mentioned earlier. This is in contrast to the schizophrenic, who notices nuances of expression and inflection, frequently in clear awareness, and then distorts their meaning. Thus a schizophrenic patient will note his therapist's tension as manifested, perhaps, by his swinging his leg during the interview. Having noticed it as tension, he will then attach a meaning to it which is inappropriate. For instance, he may interpret it as meaning that the therapist is sexually attracted to him. The manic or depressed patient will not take note of the tension phenomenon in the therapist; there may be a subliminal noticing of what goes on, but it is not sufficiently in awareness to be given a meaning. If the patient has such an occurrence called to his attention and is asked to put a meaning to it, the interpretation will fall into the category of the therapist's expressing boredom or disapproval of him. With the schizophrenic, therefore, the problem boils down to correcting a misinterpretation of an observed event; with the manic depressive, both the observation and the interpretation are awry. Once the awareness of signals from other persons is more accessible to the manic depressive, the misinterpretation is more easily corrected than in the schizophrenic.

Countertransference

While countertransference problems in the treatment of manic depressives must necessarily vary with the personality of the therapist,

there are a number of quite general responses generated in therapists which are deserving of notice. Perhaps the most striking one of these is the fact that of those psychoanalysts who are working with psychotics, the large majority prefer working with schizoid and schizophrenic patients and tend to avoid those in the manic-depressive category. This preference has been thought by us to relate to the type of character structure found in the therapists. Such persons are usually schizoid or obsessional in character themselves and as such are rather subtle, introverted persons who are interested in the observation of their own and others' reactions. The extraverted, apparently unsubtle manic-depressive is a threat to such therapists in several ways: In the first place, communicative efforts are a strain because of the lack of response. Secondly, the so-called healthy extraverted approach to reality is likely to fill the more sensitive, introspective person with self-doubts as to the possibility that he makes mountains out of molehills, reads meanings in where none were meant, and so forth. One of our therapists had particular difficulty in speaking of feelings with a manic patient, on the basis that the patient would regard all that as foolishness. Thirdly, the therapist tends to dislike this sort of person and to think of him as "shallow." And, finally, the patient's difficulty in recognizing or discussing his or another's feelings or meanings throws the therapist into a situation of helplessness, since these things are the coin in which he deals. An

interpretation which is highly meaningful to the therapist, and which he would expect to have a tremendous impact on one of his obsessional or schizoid patients, is hardly noticed by his manic-depressive patient.

We have wondered whether, on the basis of these facts, a more appropriate choice of therapist for the manic-depressive could not be made from among the psychiatrists who have character-wise something in common with them. Our data on this point is largely impressionistic, but among the therapists who have participated in this seminar there has seemed to be some tendency for greater success and greater preference for this type of patient among those with characters more nearly approaching the manic depressive than the schizoid. It should also be noted, however, that as familiarity with the problems of the manic-depressive person increased and some, however vague, conceptions of how to meet them came into being, the general feeling of dislike or distaste diminished and was replaced by interest.

Many of the therapists had countertransference difficulties with the patients' demandingness. This is illustrated by the therapeutic difficulties with the patients Mr. H and Mr. R. whose detailed case studies are included in this report. In the initial stage of treatment, the therapist tended to permit herself to be manipulated into meeting or promising to meet the demands of the patient. This is a rather characteristic personal problem of the therapist who is somewhat overinvolved in playing

a benign and powerful role with the patients. The second phase of the difficulty occurred when the therapist became aware of how she had been manipulated and then became overhostile and overrejecting. In treating both of these patients the whole treatment process was affected by these countertransference difficulties. As the reader will note, both patients show a similar course, in that treatment for the first year, or year and a half, was relatively smooth, but relatively unproductive of improvement. During this time the "honeymoon" was going on, during which the therapist was permitting herself to be manipulated in a variety of ways into fulfilling or seeming to fulfill the patient's needs. Following this phase in both patients there occurred a crisis in which the patients' symptoms became more severe, on the one hand; and, on the other hand, the therapist became consciously hostile and rejecting toward the patients. These crises came about through a recognition on the part of the therapist of the lack of progress in the patients, a recognition of the manipulative aspects of the relationships, and an increasing resentment of being so manipulated. This led to a fairly abrupt and unkind rejection of the patients. Following the crises, during which the therapist worked through some of her resentful attitudes toward the patients, therapy in one case went on to a much more productive relationship, with consequent improvement and insight developing in the patient. In the other more severely sick patient, the improvement was missing.

Another therapist consciously set the goal of meeting the patient's emotional demands. The patient was severely depressed and the therapist undertook the exhausting task of providing a sort of emotional bridge between herself and the patient. The approach proved very useful during the patient's depression; indeed, it was sufficiently successful to remove the necessity for hospitalizing the patient, a step which had been necessary in previous depressions. However, after the depression lifted and the patient became hypomanic, the treatment was disrupted. The patient became hostile and dismissed the therapist. At this time the therapist commented:

"She had developed a type of behavior which actually got under my skin--the telephone calls. When she first talked about the transference [the patient accused the doctor of 'throwing the transference out of the window'], I think that she was talking about the hostility and frustration in me when I wasn't able to protect my own life. A further element was the change in my attitude as I saw her come from depression into elation, the change in my evaluation of potentialities in this person. During the depression the sense of depth that one gets leads one to go on to believe that there must be considerable to this character. When she came out of that, in the period prior to the elation, and I began to have exposed the range of her interests and the smallness of the grip that her interests had on her, my thinking about her changed. I became overwhelmed by the fact that she did not have the personality assets; probably I came to questioning the notion that I had had about what treatment would amount to. I realized that she had reacted to my hopes for the treatment, and there was a process going on in me of giving them up."

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Another therapist found herself protected in refusing to meet the patient's dependency demands by the reflection that, since it was commonly

accepted that no one knew how to treat manic depressives successfully, her professional prestige would not be threatened if she failed with the patient. Apparently this point gave her sufficient security to deny the patient's demands without experiencing too great uneasiness. She did, however, show some vulnerability to the patient's demanding attitude in that she felt that the patient was justified in being angry at her for an unavoidable tardiness on one occasion. And on several other occasions when the therapist had to be away from town for a day, she made the probably meaningful arrangement of making up the missed hour with the patient in advance. We concluded that, even though the therapist was relatively secure in the face of the patient's demandingness, a certain degree of apprehensiveness remained of which she was unaware.

Therapeutic Techniques

Many of the topics covered in this and the previous section of the report carry therapeutic implications, since rational therapy must be based primarily upon an understanding of the patient's dynamics and specifically upon an understanding of the transference and counter-transference patterns.

All of the members of the seminar agree that the first step in therapy with these patients should be the establishment of a communicative relationship, in the ordinary sense of the term, in which thoughts, feelings, and meanings are noticed and talked about. A variety of maneuvers have been suggested for the accomplishment of this goal. (1) One

suggestion has been that the emphasis in communication with the manic-depressive be nonverbal, chiefly using tone of voice and gesture rather than emphasis on the intellectual content of the exchange, with a view toward development of more facility for noticing experiences in the area of nonverbal experience. This was done by one therapist largely by assuming this sort of role herself. (2) Another therapist feels that the usual technique, applied with more patience and more intenseness, will suffice, with the addition that it is necessary for the therapist to realize that the patient's seeming to be in good contact and able to tell a great deal about himself should not deceive the therapist into assuming that meaningful communication exists when it does not. A further point made by this therapist is that the presence of strong feelings of envy and competitiveness with the therapist keeps the patient focused on "who is better" and prevents him from working on his problems. She would use this interpretation quite consistently in the early stages of treatment. (3) Another suggested maneuver was to press the patient in an insistent manner to look for and give the emotionally meaningful material, on the basis of the assumption that the material is present and available if the therapist demands it. This would involve treating the stereotypy of the patient as a defense from the outset. (4) Another approach suggested was summed up under the name "relationship therapy," by which is meant the substitution of action for words. This would include the nonverbal technique

mentioned as point (1), and it could also include the various shock or startle experiences which have seemed to help in shaking the stereotypy defense of these patients. This latter has been explained as being effective because it was sufficiently intense and spontaneous to loosen the defensive armor of the patient momentarily and involve him in a more genuine emotional interchange. It is, of course, highly speculative whether such a sudden, spontaneous eruption of the therapist could be fashioned into a planned technical approach. However, the point remains that the conventionalized verbal psychoanalytic approach may be quite an undesirable one for the conventionalized manic-depressive patient. As one member of the seminar expressed it: "Words become very easily stereotyped, whether you use Freudian language or Sullivanian language; whatever language you use, it becomes stereotyped and doesn't convey any feeling. When you want to get at the feeling, there has to be some startle reaction."

The consensus of the seminar was that the first and foremost problem is that of getting beyond the conventionalized barrier into the area of emotional exchange. The variety of methods suggested for approaching this goal are a reflection of the variety of personalities in the seminar group. In addition to the various approaches suggested, however, there also appeared to be general agreement that looking at the stereotyped or conventional behavior as a defense against anxiety and making interpretations of it as such is a therapeutically fruitful approach.

A second point of general agreement in the treatment of these patients had to do with the handling of the demands. From the material in the section on countertransference it can be seen that there are dangerous pitfalls in this aspect of the relationship, especially since too great or impossible demands on the part of the patient are likely to mobilize countertransference anxieties in the therapist. While numerous speculations were entered into as to the feasibility of meeting some or all of the patient's demands, the experience of the years seemed to indicate that it is more desirable to take a firm and consistent attitude of refusing to meet demands from the beginning. To this must be added a certain watchfulness, lest one be out-manuevered by the patient and, while saying "no" to one demand, be simultaneously trapped into meeting another. This seemed to be the case with the therapist who was impelled to make up missed hours in advance. And, of course, this is an area where the manipulative ingenuity of the patient is particularly spectacular. We also agreed that, since the manipulative aspects of the relationship are prone to involve the therapist in various degrees of unspoken, or even unrecognized, resentment, great care and alertness should be exercised to (a) get the demandingness out into the open, and, (b) to resolve the tensions which come into the relationship by a full discussion of the reactions of both patient and therapist.

Another therapeutic difficulty which is closely related to the demandingness is the problem of acting-out with these patients. In the manic, this takes the form of ill-advised acts which do the patient's reputation or economic security real damage, or the making of decisions at a time of poor judgment which seriously alter the course of life. In the depressive, the acting-out takes the form of failure in job or life situation due to the apathy and hopelessness, or of suicide. These dangers seem to imply the need for firmness and guidance in dealing with both the manic and the depressive aspects of the illness. However, as soon as the therapist begins to play a guiding role with the patient he is meeting one of the patient's most basic demands and opens himself up to meeting more and more demands which are presented as necessary to prevent injurious acting-out. He is soon in a situation where the patient is able to re-enact with him his old pattern of dependency, while he does not know where or how to draw the line. Numerous almost humorous tales are told by psychiatrists about how they have handled suicidal threats from patients. One psychiatrist, in response to a suicidal threat told the patient, "Well, please don't do it on my doorstep." Another, when telephoned by a patient who threatened to kill himself, said, "Well, what did you wake me up to tell me that for?" A third therapist told the patient that it was against the rules for him to commit suicide, and if he did so, she would discontinue the treatment!

Laughable as these illustrations are, their effectiveness in reducing the danger of suicide nonetheless makes a point regarding the dynamics of the patient. On the one hand, a denial of responsibility for the continued existence of the patient seems vitally necessary in order to prevent the use of suicide as a weapon to enforce the patient's dependency demands. However, implicit in each statement is the doctor's admission to the patient that he is meaningful or important to him; this aspect of the problem has been referred to before. We feel that an air of blandness or indifference is quite undesirable in dealing with these patients; that a condition of involvement of themselves with their therapists, and vice versa, is necessary for their progress and even survival.

The same problem is illustrated in the management of Mr. R's acute depression. In order to avoid the necessity of hospitalizing him, the therapist was seeing him six or seven times a week. In addition, the patient was referred to an internist for help with his insomnia and saw him about twice a week. And, beyond this, a psychiatrist friend of the patient made himself available and spent an evening or two a week listening to the patient's complaints. All this attention was ineffective; the patient's tension continued to rise and his suicidal threats increased in number. It was not until his therapist grew angry and scolded him thoroughly that the patient's tension began to subside. On reconsideration of this episode we concluded that it was the fact that the therapist cared

enough to grow angry that made the episode significant to the patient. Her anger startled the patient sufficiently to push his stereotyped defense aside for a moment and permit a real exchange of feeling to occur. It seems to have been the first time the therapist ever appeared to be a human being to him, and following this first experience, later recognition of her as human became more easily achieved.

Not only in dealing with the depressive, but also with the manic, it is manifestly impossible for the therapist's denial of the patient's dependency demands to go to the length of passive indifference. In treating a manic, either within or outside of a hospital, restrictions on his activity are necessary both to prevent his destructive impact on his environment and also his destroying himself. Such restrictions are also necessary for the sake of the therapist. That is, exploitation beyond the particular level of tolerance of any individual therapist will inevitably lead to nontherapeutic resentment, and the manic will characteristically attempt to find the limits and then go beyond them.

We have concluded, on the basis of these considerations, that the manic-depressive can best be treated in a situation where certain rules are laid down for him, in an active, vigorous and "involved" way by the therapist. We feel that his demands should be recognized, labelled and refused. We feel that the therapist should not make decisions for the patient, nor attempt to give him advice on how to

behave; in fact, the therapist's pressure should be in the opposite direction--that of the patient's working through his conflicts to the point of being able to make his own decisions. The rules should be laid down in terms of setting up a structure or frame of reference within which the patient would then be responsible for working out his own personal choices and decisions. We conceive of the making of rules or setting of limitations as conveying to the patient, not only guidance, but also a sense of his own importance. To illustrate: In dealing with a depressive who was unable to eat or dress, the therapist would convey much more a sense of the patient's importance by setting up a rule that the patient must eat a certain minimum number of meals a day than by allowing the patient to starve or undernourish himself until he "worked out his conflict" about eating.

The patient's sense of his own meaningfulness to the therapist is, we believe, also promoted by the therapist's continuous attempt to convey to the patient some sense of his own feeling attitudes. Thus we would advocate the expression of resentment to a manic or depressive patient when it was genuinely and warmly felt. In the treatment of Mr. R, after the initial change for the better occurred, his therapist found that his stereotyped defenses would be dropped if she complained that she did not know what he was talking about. This can be considered to be an interpretation that he was now using a defensive maneuver, plus an expression of feeling--annoyance--about it.

As in any other analysis, the working through of the transference and countertransference with the manic depressive constitute the most important part of the analysis. The particular defenses in this kind of illness make these problems usually acute and probably contribute to the feeling among many therapists that this group of patients are the most difficult of all patients to treat. We feel that the difficulty in communication resulting from the stereotyped response of these patients is by all odds the greatest technical problem to be solved in their therapy.

VI. CASE REPORTS

Case 1: Mr. R.

This patient had a chronic character disorder, with predominantly hypomanic symptomatology which was not severe enough to interfere with his social and professional adjustment, except for one period of acute depression and an occasional episode of milder depression.

He was 35 years old when he entered treatment in 1948. Therapy continued for four years, and at the time of discontinuance, the patient had shown considerable improvement in his chronic symptomatology, as well as a lessening of his periods of depression. He was referred for treatment because of an acutely tense depressed condition which had been precipitated by his attempt to leave the Army where he had been an engineering officer, a member of the regular Army. The circumstances were briefly as follows: He had a year's professional experience following his engineering course, and at the onset of the war joined the regular Army. Following the war he had planned to remain in the Army as a career. However, he was quite conflicted about this decision and was under terrific pressure from his wife to resign from the Army and go back to the business world. Under this pressure he developed symptomatology which was suspicious of ulcer. A diagnosis of ulcer (which subsequently proved to be erroneous) was made, and after spending some time on the sick list, the patient was given a leave-of-absence to permit him to make a start in a new job. This

arrangement was made because the Army was not anxious to run the risk of having to pension him for his ulcer and also because he was extremely well-thought-of and valuable officer whom they were reluctant to lose. He went to the Middle West where he made a start in his new job, but he became more and more tense and distressed and his ulcer symptoms increased in severity. After a few months he therefore returned to Washington and was hospitalized. During his stay in the hospital he developed an acute anxiety attack in which he had auricular fibrillation for a period of five hours. His deteriorating condition convinced him that his plan to resign from the Army had been an error, and he therefore dropped the plans and made arrangements to go back to duty and began psychoanalytic treatment.

Family Background.

The patient is the oldest of three children, the other two being girls, approximately four and eight years his junior. He was born in the Middle West where he lived until the age of five and then moved to California. His father was a lawyer, a person of considerable repute and skill in his profession. He was a man who was outgoing and active in organizational things, as well as being interested in golf. He had numerous male cronies, was away from home not infrequently on trips to conventions, etc., and apparently played around with other women, drank generously, and had a good time with the boys on these trips. The father's parents died when he was very small and he was raised

by grandparents. He was an extremely choleric and unstable person at home, with a strong need to rule the household, which he did largely through fear, and a strong need to be waited on and to be the center of attention in the home. When the patient was four, his father had scarlet fever, which left him with some suspected lung trouble. Because of this the family moved to California where the father was bedridden for a year and the family lived on his sickness insurance. The family was in a terrific state of anxiety at this time because of the father's illness and the fact that he was unable to work. Following this illness the father had marked hypochondriacal trends. His symptoms largely centered around his intestinal tract and in later years also included his heart. He would work for a year or two and then get sick and be out of work for several months at a time, using up all of the savings of the family. Apparently the family was never in want but they always lived in a state of uncertainty about their being able to meet their expenses because of the fear that the father would have another illness. During his well periods, the father worried tremendously about business and overworked himself. From the patient's account there appears to be a strong indication that the father suffered from cyclical mood changes with periods of depression and hypochondriasis and periods of over-activity. The diagnosis of neurotic or psychotic depression was never made, and his illnesses were always treated as though they were on a physical basis, until the last few years of his life. In addition to his

other symptoms, the father also drank excessively. The family felt extremely ashamed of this behavior and made every effort to conceal it from the neighbors. The physical ailments were more acceptable and not so great a source of shame. There was one episode during the patient's childhood when he was about nine or ten when the father attempted suicide by starting his car in the closed garage. The father was missed and the patient sent to find him. He did find him in the car and persuaded him to come home.

In spite of the father's afflictions, the patient was extremely attached to him. He made repeated efforts to become intimate with his father, asking him to let him go along for the golf games and be his caddy, wishing that his father would take him camping in the mountains, and so on. The father alternated between treating the patient nicely and being very rejecting of him. The patient recalls that when the father was friendly, he became delighted and overeager like a puppy dog. His behavior would then offend the father and he would be pushed away. The father always was extremely disciplinary toward the patient. For instance, when the patient was struggling along in Latin with a "D," the father requested his teacher to flunk the patient in order that he would learn a lesson from it. Then the patient was left home to repeat the Latin while the rest of the family went on a summer vacation trip. The patient was extremely active in sports and school activities. He was always anxious for his father to come and watch him swim or perform

in the band. Occasionally his father allowed himself to be dragged to these performances, but never gave the patient any verbal praise. He would, however, brag about his son to his friends.

During his childhood and early teens the patient's relationship with his father alternated between eager seeking for his affection and attention and bitter quarreling with him. They would frequently get into arguments at the dinner table, which would end in a row with the father leaving the table and going out of the dining room by one door, while the son left the room by another. By the time the patient was in his late teens, the relationship between himself and his father changed so that the patient became the paternal figure. He gave his father good advice, took an interest in his father's physical ailments, prescribed medications for him, and was extremely attentive to him. He also was very much preoccupied with a need for his father's approval and much of his desire for success was motivated by a wish to make his father proud of him. As this adult relationship developed, the quarreling dropped out. The patient's father continued his pattern of recurrent depressions throughout his life, and died of a coronary when the patient had been two years in treatment. The autopsy revealed a severe coronary artery disease and ulcerative colitis with numerous adhesions. Shortly after the father's death the patient went into a severe agitated depression.

The patient's mother is a much less significant person in his awareness than his father. She is described as a quiet, passive, conventional woman whose main desire was to keep the father going, make a good impression on the neighbors, and keep peace in the family. She used to try to soothe the patient's wounded feelings about his father with an empty sort of reassurance that his father really loved him after all, and that he was really a good boy and everything was going to turn out all right. The mother apparently took little part in controlling or management of the home. Father made the major decisions about purchases and planning. The mother did her housework and left the rest to him. She was considerably more intimate with her daughters than with her son, and they have remained quite closely attached to her in their maturity.

The patient felt that his mother was cold toward him and also that he was too rough and uncouth to please her. He would from time to time give her a friendly squeeze or slap and would be told not to do that because she bruised easily.

She was tremendously preoccupied with the possibility that she might have had breath and would frequently tell the children not to kiss her because she had not brushed her teeth. The mother had an attack of pleurisy when the patient was two-and-a-half or three years old, and was sent to Arizona to recuperate. The patient went with her and was then alone with her and separated from his father for a period of

two or three months.

The patient's two younger sisters are both married, with children. The elder is a chronically hyperactive nervous woman whose children are problems. The younger is more stable, although obsessively clean, rigid in character, and extremely dependent on her mother. The patient was brought up to be a good older brother to his sisters and has no memory of quarreling with them. He does remember feeling envious of them because he believed that both his father and mother liked them better than they did him. His father was more openly affectionate toward them, and the mother and they had a sort of feminine intimacy from which the patient was excluded. They were presented to him as being very pure, nice girls, and he was taught that it was his duty to protect them, to squire them around when they were learning to dance, to find boy friends for them, and to see to it that no harm came to them. He carried out this role very dutifully, took a paternalistic pride in supervising their choice of boy friends, taught them both to dance, and was looked up to by both of them with respect. The relationship with the sisters and with the mother was so extremely formalized that there was little or no communication between them except the exchange of platitudes. Letters written by both mother and sisters to the patient consist entirely of a string of platitudes about what a wonderful fellow the patient is, and advice not to work too hard, and hopes for his welfare.

There were a few occasions during their early teens when the children played naughty games together when their parents were away from home, and the patient had some memory of feeling attracted to his sisters at these times.

Developmental History.

The patient was a frail baby who was undernourished because his mother lacked milk. He was fretful and crying for the first six months of his life, and he has been a feeding problem throughout his life. This is still apparent in adulthood, particularly when he is depressed, at which time he becomes almost unable to eat and lives on Coca-Colas.

At the age of four, several traumatic occurrences took place in the patient's life. He was circumcised; he had his tonsils removed; and he was run over, suffering a broken leg. These were three separate occurrences, but they happened within a short time of each other. Following these events, the patient's sister was born, and the patient's father's scarlet fever occurred. So within a period of a year or a little more, a series of disturbing situations arose.

After the move to California, the paternal grandfather lived with the family for a number of years. The patient was rather attached to him but found his messiness quite repulsive. One of the mother's sisters spent a good deal of time with the family also. She is remembered by

the patient as being a forceful and rather rough person whom he disliked.

The patient's childhood was characterized by hyperactive inability to concentrate, frequent accidents in which he broke various bones and otherwise injured himself, and by his being constantly in trouble with his father. The patient was already oppressed by the need to please both his father and mother, but extremely awkward and unsuccessful in doing so with either. His need to please authorities is illustrated by the fact that he saved all of his report cards from grammar school and early in his analysis brought them to show the therapist what sort of performer he had been.

During his later childhood years, he spent less and less time at home. He would frequently go to the movies and stay most of the afternoon and evening. He also joined a boys' group at the "Y" and another boys' group at church, the activities of which kept him quite busy. He learned to play the trumpet and was in the band. He became an excellent swimmer and was on the swimming team. He was away on camping trips, and so on. He always felt underprivileged at home and when the Christmas gifts were given, he felt that his sisters got more than he did. He would not ask to have a birthday party, but would be hurt and resentful when his mother did not realize his desire to have a birthday party and did not automatically give one for him.

When he was about eleven or twelve, the basement room was done over for him as his room and he moved down there, and, in a way, lived as a sort of outcast at home. He had his dog whom he felt to be his only

friend. He used to keep pornographic pictures in his room in the basement, and lived a rather isolated life down there with his dog and his pictures.

Although he had a hard time with his studies, he succeeded in getting through school with adequate grades. His heterosexual development occurred at about the usual age. There had been a few sexual episodes with some of his boy friends prior to this, but they seemed to have been relatively unmeaningful to the patient. He had a number of fairly close and intimate relationships with boys his own age. When he became adolescent, he idealized the girls who were ladies like his sisters, felt that they were too good to touch, and that he must never make sexual advances to them for fear of what they would think, and for fear of what his mother and sisters would say if the girls told. He used to carry mints around in his pocket, partly in order to have something to offer the girls to lessen his discomfort with them, and partly in order to conceal any bad breath he might have. His sexual relationships occurred with prostitutes. He went frequently to whorehouses and at the age of eighteen or nineteen contracted gonorrhea. This frightened him so that he confided in his father, who was fairly kind about it and not too disapproving. The patient went away to college, joined a fraternity, and lived an apparently successful college boy's life. He was unable to make up his mind what career to follow. At times he thought of law, but was discouraged by his father. He took a pre-engineering course, but was unable to make up

his mind to go through with the training. He worked for a few months and was extremely dissatisfied with that, so at the last minute he resolved to apply for engineering school, and with a great deal of running around, pulling strings, and using influence, he was accepted in spite of the fact that his application was late and his grades were not remarkable.

His studying improved in engineering school. He was in love with a girl in college who was several years younger than he was, and they were semi-engaged. However, the patient was unable to convince himself that his girl was really serious about him, was extremely jealous of her, and eventually became so tense and concerned about the relationship that he broke it off in order to spare himself any more uncertainty. He then remained uninvolved until the last year of his course when he fell in love with another girl and married her within a few months.

The patient was quite dictatorial about the arrangements for the marriage. He insisted on his fiancée's giving up her own studies, on an early wedding, and on their moving into his parents' home to live while he finished school. His fiancée acquiesced rather reluctantly in these arrangements and carried a great deal of resentment about them from then on. She disliked his father intensely and resented the father's interference in their lives. The father, for instance, would rearrange the furniture in the patient's and wife's room without her permission. The

newlyweds were also subject to a great deal of comment and teasing by the father about their sex life.

The patient's attitude toward his wife was extremely ambivalent. While he had been very insistent on marriage, he also felt trapped by it. He resented his wife's having wishes of her own; he disliked her singing, which was something that was quite important to her. He forbade her to smoke and he found it quite objectionable that on the morning after their marriage she dressed in a sweater and skirt and bobby socks. He felt that she was making a fool of him and representing herself as an adolescent. He was extremely preoccupied about his sexual performance, felt obligated to satisfy his wife, and felt that he would be unable to have intercourse as often as she would wish. His sexual performance, while objectively satisfactory, did not give him the feeling of satisfaction and relaxation that he wished for, and he was frequently forced to engage in fantasies of intercourse with prostitutes in order to reach orgasm.

The patient's wife apparently acquiesced in most of the patient's managing of her during the early years of their marriage, but as time wore on, grew more and more embittered about his treatment of her, and by the time the patient entered therapy she had become an argumentative, bitter, nagging woman who threw past happenings up to him on every occasion.

After the patient entered engineering school, the quality of his work improved markedly. He was a favorite of the professors because of his intense energy and devotion to his work. He made plans to enter a well-established firm in the East and to leave his wife behind in California while he got started. However, the war interrupted these plans and the patient joined up. Prior to his leaving for the Army, his wife became pregnant--this was a planned pregnancy. He recognized that his plan to move East as well as his hasty entry into the Army were both devices to get away from his wife. However, leaving her pregnant when he went away to war represented an impulse in the opposite direction, a need to tie her to him.

Soon after entering the Army, the patient was assigned to duty overseas. On one occasion, during a heavy bombardment, the patient became panicky and left his duties. His failure to carry out his responsibility went unnoticed, but it became a source of ever-present guilt to him, and he brooded about it for years. After several months in the field the patient returned to the United States for further training. He had become exceedingly anxious and apprehensive at being in the battle area and had managed to get into a training course in order to get away from the danger zone. On completion of the training course, he was to be sent back, but he developed an attack of so-called appendicitis. His appendix was removed and apparently was within normal limits. Following this

reprieve he succeeded in going back to duty with his anxiety still concealed.

His wife had been with him during this period of training and another pregnancy had been started. There were terrific quarrels between them at this time, during which the patient was irascible and unreasonable and occasionally assaultive toward his wife. Another short period of service overseas was followed by the patient's being returned to this country for a desk job. Here he functioned with tremendous efficiency. He was a liaison officer with the task of acting as liaison man between three departments of the Army. Dealing with and successfully manipulating the vast variety of complex situations which arose suited his abilities very well and he pleased his superior officers, accomplished a tremendous amount in his job, and was reasonably well satisfied with himself. However, when the war ceased, he began to feel that only the deadbeats stayed in the military services and that it behooved him to leave the Army and succeed in competitive business in order to be respectable. It was at this time that his acute breakdown occurred, which brought him into analysis. By this time there was a third child, just born. The two older boys were problems to the patient. He felt the oldest to be a mama's boy, since he had been away during most of that son's early childhood and the boy was overly attached to his mother. He disliked his second son because he felt the second son took after him, and he saw all of his own bad traits in

the little boy. He did become very attached to the third child and felt that this child was actually the only one in the family with whom he had a warm relationship.

Course in Treatment.

The patient was referred to me by a prominent male analyst, but he entered treatment with a strong suspicion that I was incompetent because I was a woman. He argued with himself about this, saying to himself that since Dr. _____ had recommended me, I must be good; but, on the other hand, women were deficient in understanding and unreliable so that he probably was making a mistake to come into treatment with me.

His initial attitude toward me was a blend of contempt, suspicion, hostility, and competitiveness. He felt that, like all the women he knew best, I, too, never said what I really thought, and that I would be sure to give him a lot of empty reassurance just to quiet him down, rather than telling him the truth.

He spoke continuously and fast, as if to prevent any interruptions, jumping from subject to subject with machine-gun rapidity. Whatever subject he talked about was never discussed in any organized or complete fashion, so that his productions amounted to a series of confused and rather disconnected remarks about one topic after another. He prided himself on his rapidity of speech and expressed the belief that since he thought so rapidly I would be unable to understand or to keep up with him. This he

compared to his mother who, he said, never understood anything he tried to talk about. In addition, it was quite obvious that he never listened to anything that I said. My comments were not responded to as though they had been heard or assimilated. To these negative attitudes was added his conscious statement and belief that he had no personal response to me whatsoever, but that he regarded me as being neuter, like a piece of furniture. This accumulation of negative attitudes put me under considerable pressure. I found myself attempting to prove to him that I was not as contemptible as he considered me, by making intelligent and meaningful statements about his communications. This, of course, was utterly impossible, since they were essentially meaningless and I was guessing or presenting hypotheses to him which were, whether correct or incorrect, simply denied any validity. The essential interpretation was not made at this stage of treatment, that his attitudes were defenses, stimulated by his fear of being domineered by me. Much of his production had to do with his inordinate need for approval from his superiors. He had, in fact, achieved a very high degree of success in winning approval from his superiors, but he lived in fear lest they turn against him from day to day, and he was under continuous pressure to accomplish new things in order to keep secure the approval he already had. His whole interest was focused on his relationship with superiors and he had little or no contact

with his contemporaries at work. He never, for instance, took time out to sit around and talk with the other fellows, but was always to be found working furiously at his desk or dashing about from department to department.

His family relationships occupied an equally insignificant place in his life. He spent a great deal of time traveling, and when he was living at home, he was as likely to be playing baseball or working in the evening as he was to be actually at home. He would quite characteristically be away from his family five nights a week.

Treatment went along for about a year without any demonstrable change in the patient and without any progress toward working through the transference defenses. After that time it was suggested to the patient by one of his fellow officers that he ought to apply for a medal for his part in the war and he found the idea very tempting. When this was discussed with me, I attempted to discourage it, without coming out directly with a strong effort to interfere, and the discouraging words I said were unheard by the patient. He went ahead with a series of manipulative acts designed to win the medal, and it was awarded to him. No sooner had he received it than he became acutely anxious and tense. He began to suspect his compeers of envying him and plotting to injure him in order to punish him for having taken advantage of them by getting a medal for himself, and he thought that his superior officers were contemptuous of him for his greediness. His life became a nightmare of anxiety in which he misinterpreted the smiles,

glances, gestures, hellos, and other superficial behavior of his fellow officers as signifying their hatred and disapproval of him. He now began to reproach me for not having prevented him from getting the medal. He maintained that I should have realized the effect it would have on him and put my foot down before he acted.

At this time his father died rather suddenly and the patient went into a quite severe state of agitated depression. He was unable to sleep or eat, and he paced the floor, wringing his hands, uttering self-reproaches, and continuing to ruminate about the catastrophe which he had brought upon himself by getting the medal. It was felt that his military career would be more secure if he were able to stay out of a hospital during the period of this depression, and a whole series of expedients were resorted to to tide him over without hospitalization. He took some sick leave; his mother came; he increased the number of his interviews from three a week to five or six; he was sent to an internist for assistance with his sleeping problem; and, in addition to his daily hours with me, he had interviews with a male psychiatrist who had once been a fellow officer of his.

During his hours with me, however, his agitation remained undiminished, suicidal threats became more and more frequently, and the necessity for hospitalization became ever greater. There was a great deal of hostile attacking of me in indirect ways during this time, always

with the implication that it was my neglect and stupidity which had brought him to the pass he was in. I grew more and more discouraged about carrying him as a private patient and finally became so anxious that I lost my temper with him and gave him a thorough scolding. The patient reacted to the scolding with a sort of paralysis. His agitated behavior rather promptly ceased. He began to show interest in hearing what I had to say about him, and within a period of two weeks, the depression had receded to the point where he was able to carry on a relatively normal life again. This dramatic change was clearly a consequence of the harsh treatment he received from me. There was in my attitude toward him both a counterattack--that is, blaming him for his own difficulties instead of accepting the blame he had been laying on my shoulders--and also a threat that since he was doing so poorly in his treatment with me, I would discontinue seeing him.

The patient was unable to report very much about his reaction to the scolding except that one of his first questions was whether I really meant it, or whether I was putting on an act in order to frighten him into behaving himself. I told him quite clearly that it was no act, but a spontaneous expression of my resentment toward him and my discouragement about him. This was extremely reassuring to the patient, apparently because it took me out of the character he had assigned to me on the basis of his experience

with his mother, and put me more into the pattern which he was comfortable in dealing with in his father. It, so to speak, made him respect me. From this time on, therapy continued on a more satisfactory basis. There was more exchange, more real communication, less of the machine-like flight from one topic to another, and more real expression of affect.

The patient continued in treatment for about two years following the acute depression, and during this time worked out a great many of his conflicts. The overattachment and overidentification with the father came to be seen as, in part, a method of covering up his intense resentment of his father. The resentment sprang from the father's quite overt hostility toward, and rejection of, the patient, and it was seen that much of the father's hostility toward the patient had represented his jealousy of the patient, and his need to keep first place with the patient's mother as the favorite son. The patient's reaction to his father's jealousy of him could be seen in his attitude toward the males with whom he worked. Here, following the achievement of the special recognition represented by the medal, the patient went into a quite panicky state in which he believed that he was receiving hostile glances and sly innuendoes from the other men expressive of their resentment of his success. He engaged in a rather marked degree of projection in attributing these attitudes to the other men and only worked through this pattern when he began to recognize the

projective nature of his beliefs and to note that the degree of severity of his projective mechanism fluctuated according to the level of his own anxiety. He then eventually learned to look for the anxiety-arousing conflict as soon as the projective thinking began and in this way was able to discontinue using it.

Another aspect of his relationship with men was, on the one hand, his fear of intimacy with them, and, on the other hand, his tendency to put himself into the promising young protege role with any man whose status or whose ability was significant to him. The need for friendship or companionship with males was largely out of awareness, and when he did establish confidential relationships, it was usually on an inferior-superior basis. This fear of, and avoidance of, equal and intimate relationships with men diminished somewhat in the course of treatment, but was not completely worked through, and at the time of stopping, the patient still led a relatively barren life as far as male friendships were concerned.

The relationship with the mother came to be understood during the course of treatment as being, to a great extent, interfered with by the previously mentioned fear of the father. The patient symbolized this difficulty with his mother when he went home to attend his father's funeral. He found his mother lying in bed when he arrived home and lay down beside her while they both wept over the loss of the father. During his severe depression his mother spent some time with him in his own home, and

the patient expressed the belief that if he could "get close" to his mother this would make him feel better. He was, however, unable to achieve any feeling of intimacy with her. He felt that she was a very hypocritical person who never said what she wanted, but only said that everything was all right. She never had any differences of opinion with anyone, and she had no criticism of him and she was sure that everything would turn out for the best. This empty type of reassuring verbalizing became very offensive to the patient during the course of treatment, although he had, prior to treatment, been accustomed to expressing himself in exactly the same way to his mother and he had had the illusion that he and his mother had a very close relationship. After having seen that this fantasy of closeness was illusory, he became very hostile toward his mother, constantly picked on her and tried to get her to say what she meant rather than the polite thing, and actually became unable to see anything about her which was even likeable, much less lovable. Instead, he found her increasingly blameworthy about all of the difficulties of the family. He accused her of being a castrating woman who was responsible for his father's inadequacies, who made his father a weakling by giving in to him and who cared nothing for her children except in terms of using them to please the neighbors and keep the father quiet.

Concurrently with these feelings against his mother, he became quite consciously hostile toward his wife for the first time. While there had been

a great deal of undermining and critical behavior evidenced toward his wife, there had been no consciousness of critical feelings toward her. Even the early plans to get away from her--by entering a firm in the East and leaving her behind in California--had been so thoroughly rationalized that the patient was unaware of the need expressed in these ways to avoid her. He acted out some of his hostility toward his wife by starting an affair with a young woman who he felt understood him better. He was, however, quite guilty about this liaison and his potency was low. In the course of this liaison he arranged for his wife to spend several months away from him in her home town. He had fantasies of living a free bachelor-type existence while she was gone, but found in fact that he was so dependent on her and so lonely without her that his pleasure was minimal. Upon her return he persuaded her to undertake some psychotherapy, and following this period their relationship began to improve. There are some very real differences between them which represent relatively insoluble difficulties in the marriage. For instance, the wife is an extremely stubborn, rigid, argumentative woman who is limited in her interests and inflexible in her patterns of living. Her psychotherapy was on a fairly superficial level and these character traits have remained relatively unchanged. The patient therefore is faced with the problem of the inability of his wife to share in the broadening of his own interests which has come with his more intensive therapy.

The last remnants of his infantile dependency have shown themselves in his inability to accept either his mother or his wife in terms of what they are, his chronic insistence on their changing and becoming more gratifying to him, and his persistent accusations against them as being the source of his difficulties.

When treatment was discontinued, both of the above-mentioned problems--namely, the inability to accept the reality situation as far as his wife and mother are concerned and the inability to carry out a satisfactory relationship with a man friend--remained partially unresolved.

The patient returned a year later for a relatively brief period of work, during which the infantile dependency on the analyst was further worked out. He had not liked the duty to which he had been transferred and began trying to make plans to be shifted to some other duty during which one of the prominent fantasies was that I would make this shift possible for him when he let me know what he wanted. When it became apparent that this would not happen, he became depressed and returned for a few weeks of therapy. For the first time in therapy the demands on me and the hostility resulting from the frustration of these demands were quite open. The process was initiated by a great many projective thoughts about my poor opinion of him, my secret belief that he did not deserve a better job, my contempt for his ability, and my intention and

wish to get rid of him; but the projections were quite easily seen through, and then the pattern of the fantasied demands, the resentment when these demands were not met, and the subsequent projected hostility, became quite clear. At the present time, then, the patient has worked through another episode of his depressive reaction which is his response when his infantile demands are not met, and his level of adjustment is somewhat more mature as a result. It remains an open question whether further work will be necessary to completely resolve the remainder of his dependency.

Case 2: Miss G.Presenting Illness

The patient, a 21-year-old young woman, came to see the present therapist in the spring of 1948. She had become depressed while attending college. She had gone to this particular college to be near a girl friend whom she had met while in a hospital. She had been dating a boy who was engaged to be married to someone else and one day he told her that he really intended to marry his fiancée. At about the same time the patient had a quarrel with her girl friend. These two events apparently precipitated a depression sufficiently severe that she had to consult a psychiatrist at school whom she saw two or three times. She continued to be so low in spirits that she decided to come home, where she found that she was disinterested in everything, did not want to go out, felt ashamed to see people, and felt completely unable to try to get clerical work, although she had held such jobs before. She did not wish to go back to see the psychiatrist in her hometown whom she had seen briefly for a depression prior to going to college. She felt he had been partly responsible for her going to college, and hence for her failure. The family consulted a third psychiatrist who had seen her even earlier. He was unable to see her, but recommended the present therapist because of her experience with college students.

The father came first to see the therapist, and expressed an urgent need for help, reporting that his daughter was depressed, lacked all

interest in her usual activities, talked only a little, and practically never to her mother. He reported that the patient had been in similar depressions on three other occasions, at which time she had had psychiatric help, with some improvement. She had had two previous admissions to hospitals, the first of two months' duration and the second of four months' duration, with an interval of two weeks between them. On discharge from the second hospitalization the patient had improved sufficiently so that she was able to work and get along well. She continued to see a psychiatrist on an outpatient basis. From time to time she talked about going away to college. With psychiatric assistance, she was able to do so in the fall of 1947. After a few weeks the depressive symptoms had recurred.

The mother came with the patient the following day for the patient's initial interview, and the therapist saw the mother first alone. The mother evidenced none of the urgent concern the father had shown about the daughter. Her attitude was that her daughter was difficult, but that this was because of mishandling by her husband. She said she had always disapproved of his concern about the daughter; for instance, he insisted on having the daughter accompanied to school, and he refused to let her be out alone. One of the former psychiatrists had agreed with the mother that the father's overprotection was detrimental to the patient. The mother also implied that the father's seeking

psychiatric assistance for the patient was another evidence of his over-concern. Jane, the patient, accused the mother of preferring the sons, but the mother said that this was not true--she liked her three children equally. She was obviously uneasy and embarrassed when she was asked about the infancy and childhood of the patient: she said the daughter's early physical development was normal with no difficulties.

The patient herself had a lifeless and sombre expression, and she seemed rather cautious, giving the impression of guardedness, but not appearing particularly suspicious. She had a slightly olive complexion and good coloring; she was somewhat stocky in build, pyknic, and somewhat overweight. She was conventionally dressed. She said nothing spontaneously, but she responded to questioning. She confirmed her father's statement that she felt low in spirits; she was not interested in anything, except eating, which she was doing somewhat excessively at that time. The overeating bothered her mother. There was no difficulty in sleeping; rather she was sleeping more than usual, she said. She denied that she had suicidal thoughts.

Personal and Family History

The patient was born in 1928, the second of four children. All of the other children were boys. The children were born at about two-year intervals. The family is of Jewish extraction. They had lived in a West Coast city until the patient was six years old, when the father

gave up a successful legal practice to come to Baltimore, with plans for changing his legal specialty. These plans did not materialize, however, and the economic situation of the family deteriorated. In order to make a living during the Depression, the father was finally "forced into court reporting," in which he has continued, with increasing financial success. He has shown marked shame about his occupation for as long as the patient can remember. He has constantly talked about returning to law practice, and, from time to time, he has made plans to do so.

As far as the patient knew, her early development was normal. Menstruation occurred at the age of 12, followed by a brief period of amenorrhea. Her physical health has been unusually good, with the exception of a tendency to frequent and mild colds. The father, throughout her life, has worried about her health. He was continuously preoccupied with whether she looked pale or flushed, and he took her temperature every morning.

The patient had only brief contacts with other children in her early years. She had one girl friend. She became intensely jealous when another girl attempted to make the group a threesome; the patient became so dictatorial toward this intruder that the girl dissolved into tears. In the end the patient felt that her friend deserted her in favor of the new girl. The mother's frequent disapproval of her

friends markedly lessened her opportunities. The mother was preoccupied with the status of the families involved. The difficulties were increased by the father's insistence that the patient should not go out alone. But in this area a tacit conspiracy seems to have arisen between mother and daughter: the patient did go out alone occasionally, but great care was taken to conceal this from father.

She once started Sunday School, but stopped when father fussed about drafts, and so on, in the Sunday School room. From then on she never attended any religious services. Neither parent attended church, but the mother usually observed religious holidays in the home, with special food, and so on.

Her academic record was excellent until the last year of high school when her marks declined somewhat as she became preoccupied with future plans. The patient felt that her father was not interested in her high academic achievements, but only noticed her poor grades. The mother paid little, if any, attention to her academic achievements. Through school activities, the patient became interested in cooking and decorating the home, but she felt that her mother was unresponsive to her new-found interests. The mother was a highly efficient housekeeper who liked to do things herself. When the patient was older, the mother occasionally asked her to do something but the patient always felt that the uninteresting and less difficult things were left to her.

The father was in his middle fifties at the time the patient began treatment with the present therapist. He was always unhappy, discontented, and ashamed of his work. He talked continuously about giving up his job, getting another one, or going back into law. There were continuous complaints from the father that the mother was a poor cook, and at times the father was so explosive that he would throw dishes at the mother. The mother usually sat impassive throughout this performance, except for an occasional mild remark that the food was all right. He complained that his family were millstones around his neck, and that he would have been a success if it were not for them. He would often slam out of the house in anger, and the patient was always in doubt as to whether he would return, although he always did. Mother never sent the children to bring father back. Sometimes the mother would walk out of the room, and, on a few occasions, she left the house. Father always sent one of the children to bring her back. Usually the patient would be sent; when she found her mother, there would be no conversation; they would take a brief walk together and then return home.

The family had few social contacts except for their visits with relatives. In the patient's early years, before the family moved to Baltimore, there were frequent visits to paternal relatives; and when they moved to Baltimore, they lived for a period with paternal relatives there. Living space was crowded and the relatives refused to

allow the arrangement to continue indefinitely. The family moved to separate quarters, which were less comfortable than the ones in their former home. In summers they visited maternal relatives in Maine. The patient liked and admired an unmarried maternal aunt whom she got to know on these summer excursions. Father was disparaging about the maternal family, and particularly vehement about this favorite aunt. He disapproved of the aunt's interest in feminine adornment and the fact that she obviously enjoyed being with men. He was particularly vituperative when the aunt took an occasional trip to Miami, implying that her trips were solely motivated by a promiscuous interest in sex.

The mother had very few friends. She occasionally visited a woman acquaintance, always admonishing the patient not to tell father where they had been. The patient noticed that her mother talked with liveliness and interest to other people--salespeople, and so on --when she was away from home. She recalls an incident from early childhood when her mother quite anxiously hurried home after she thought that a truck driver had looked at her a little longer than necessary.

The patient and her mother liked to go to movies. Although the father also liked movies, he accompanied his wife and daughter reluctantly. If mother made a stand about his going with them, he gave in

in a very abused way; if he then found parking difficult, he would blow up and say it was mother's fault for making them go. When they took trips, the father always blamed the mother for any difficulties about hotel reservations or the like.

The present therapist has little data about the three other siblings. The oldest boy is at present a trial lawyer, married, with two children. The oldest of the two younger brothers was hospitalized with stomach ulcers a month after his marriage and subsequently divorced his wife. He has been rather unsuccessful in the business world. The youngest brother is still in school. The patient had no intimacy of any kind with the oldest brother, but she was on better terms with the younger brothers, although there was never any real intimacy or sharing of activities.

At the time that the patient completed high school, her parents wanted her to go to college. But this involved her leaving her home and parents--something which she felt emotionally unable to do. She felt that this was a great disappointment to her parents. She found herself a clerical job in which she was happy and successful. Her happiness was largely due to a relationship that she formed with a young woman in the office--her most successful relationship up to this time. At one time, this friend and the patient attempted to make some plans together, and the patient, who was unable to compromise and unaware

of her inability, became quite upset. They were estranged for a while and the patient was in one of her depressions because of this. In all of the various clerical jobs she held, the personal relationships seemed to be of more importance than the work itself; however, the work was always successfully performed.

During this period she began to date several young men, with no particular interest in any one of them. Her father was extremely upset by her dating. She usually left home for a date with the feeling that her father's evening was ruined. During the war she went to several USO parties; although her mother expressed concern about her meeting strange soldiers, her father raised no objection at that particular time. (This change in her father's attitude was probably due to his talks with the patient's first psychiatrist, who had suggested to the father that he had been too domineering; the father took this advice literally and indiscriminately.) It is interesting to note that when the father became more permissive about her dating, her mother became concerned, so that the patient was still in the middle.

When she first began to date, she became interested in collecting voluminous notes on jokes and witticisms from radio programs and from her reading. She often consulted these notes before going out on a date so that she could make witty remarks. If she were out with a group of boys and girls, she would sometimes make a remark that

other girls in the group would tell her they considered inappropriate. In treatment, she spoke of these girls as being of real assistance to her.

Course in Treatment

Additional collateral data from father: At the time that the therapist began to treat the patient, she was able to give the patient only one 2-hour interview a week, although she promised the patient more time as soon as this was possible. After about three weeks of this arrangement, the father came to see the therapist and demanded, in a belligerent way, that the therapist see his daughter more frequently. The therapist told him firmly that this was not yet possible, and reminded him that she would give the patient more time as she could. Although he acted somewhat injured, his belligerency subsided rather quickly. He implied that this was the first time that his daughter had received any real help, and felt that there was no justice in the fact that once real help had been found the therapist did not have enough available time.

The therapist asked him at this time for further data on the patient and the family and received the following additional information:

The father reported that his wife and her family had taken advantage of him; that he had been a young, unprotected law student, and before he knew it, he was married. He was most bitter and scornful

when he mentioned the fact that his wife was not a virgin when he married her. This attitude was in striking contrast to the incidental, casual way he spoke of having been later involved in an extramarital affair which his wife found out about. Although he did not go into any details, he implied that it occurred in a setting of considerable scandal. This appears to have preceded, and almost certainly was a factor in, the family's move to Baltimore. He spoke of the hard time he had had when he first made the move, and emphasized that it was at the time of the Depression and that, to keep them from starving, he was reduced to taking a job in a court reporting firm, which was obviously deeply humiliating to him. His salary was low and continued to be for some time until it gradually improved. Although his job finally paid extremely well, he brushed this aside by mentioning the disgrace of his occupation. When he was asked why he had insisted on his daughter's being accompanied to and from school, he looked genuinely startled, and finally responded, "I don't know." As the scorn and hatred for his wife was revealed, it became fairly obvious that he had never trusted her since he discovered her lack of virginity. For years he had called home daily at three o'clock, ostensibly to know whether the patient was home from school, but probably to check on his wife. (The patient later reported that occasionally he would come home at unexpected times, and would be extraordinarily uneasy to find that his wife was out. The patient always made excuses for her mother, and tried to give reasonable explanations for any delay.)

Therapy with Patient:

The therapy began with one 2-hour interview per week; later it was changed to one 1-hour interview and one 2-hour interview per week, and then to three 1-hour interviews per week. Although the father demanded more frequent interviews at first, the patient never expressed any dissatisfaction with the arrangements. Only once was she able to slightly complain about the time of the interviews and this happened when the scheduling conflicted with her work schedule. The pressure seemed to be because she did not want to tell her employer about the nature of the appointments.

In the early months the patient talked considerably about her mother's preoccupation with the patient's overweight. She began to lose weight and is at present average weight for her build. She showed little spontaneity. There was never any real sparkle, although there was evidence of some sense of humor. The therapist quite early became rather wary about the patient's laughter because it seemed close to pain. The therapist also noted that when the patient felt anxious she had breathing difficulty, somewhat like a sharp sudden spasm.

In the early weeks, the patient was full of complaints. She was not interested, could not go out, and could not work; she had a hard time with her mother, who had no concern about her suffering. She presented these complaints in the spirit of, "This is what is the matter; why don't

you do something about it?" There has been a recurrent complaint that the doctor does not help her.

In the sixth month of the work, the father called the therapist to say that his daughter would not be able to keep her appointment because she had taken an overdose of sleeping pills. He said that the mother was against taking her to a hospital. The therapist responded with real concern, and was insistent that an internist see the girl. The father came to see the therapist at the time of the daughter's usual appointment. He reported that the patient had wanted him to cancel a proposed visit of his brother and sister-in-law, but he had refused. It was in this setting that the patient had retired to her room and taken some sedatives which she had hoarded. The father gave the impression that he had reached the limit of his endurance with his daughter. From what he said, it was clear that the mother was more bothered that people would find out about the suicide attempt than she was about her daughter's safety. The therapist was shaken by the apparent callousness of the parents. She attempted to make clear to the father that with depressed people there is the constant burden of a possible successful suicide attempt. The patient missed only the one appointment (the only one, incidentally, throughout the whole course of the work). She said that she had been disturbed by the relatives' coming and seeing her in her condition. When she was unable to get her father to stop the visit, she

felt that there was nothing else to do. The therapist attempted to make clear to the patient that although she knew she would be unable to stop the patient when she had suicidal impulses, she hoped the patient would be able to stay alive and give herself a chance to get well with the help of the therapist.

Undoubtedly at this point in the work a different aspect of the countertransference came about. The therapist discovered that she was more involved with the patient than she had realized and that she wanted the patient to stay alive. Two aspects of the countertransference became clearer: the therapist's interest in the patient for research; and the therapist's interest in maintaining her reputation with her colleagues. Although this usefulness of the patient to the therapist undoubtedly continued to operate to some extent, the therapist became aware at this time that she cared for the patient in her own right.

Eight months after treatment began, the patient was informed that the therapist was moving to Washington, which left the patient two alternatives: changing therapists, or following her present therapist to Washington. She decided to follow the therapist, although this meant leaving the family. However, there was never any serious indecision on her part, or her parents' part. There was no interruption in the interviews during this transition period.

The patient moved around several times before she made satisfactory living arrangements. She complained about a variety of

inconveniences--but all of them seemed to be somehow related to her need for intimacy and her loneliness. She has been in her present situation, with a married couple, for over two years, and there has been none of the previous complaining. The patient's relationship with the woman has been comfortable, but she feels rather uneasy with the man of the house; however, she has little contact with him. There are usually three other roomers in the house. One of these roomers is a young girl around the patient's age. This girl is in the theater, and the patient describes her as glamorous and self-reliant. Apparently the patient considers this girl a friendly helper.

Part of the complication in getting living arrangements settled was that she had to make arrangements for cooking privileges. Although this was partly for economic reasons, it seemed to be much more related to the patient's concern about her diet. The patient described how important it had been in her early childhood to have the right and essential foods. So many restaurants were unsuitable because mother did not approve of them. The depth and extent of this worry about food was considerable and it brought up the question of her concern about her physical weakness and the absolute necessity for health precautions. Here the effect of both parents became clearer. The father made her feel concerned about her frailty and weakness of body by his preoccupation as to whether she was pale or flushed, his

office. She did not do well at all in one job where a woman was in charge. In one situation she was quite startled when, although her work was satisfactory, she was called down for taking extra time at lunch and spending too much time in the ladies' room. It was difficult to be sure whether her astonishment was because her unsatisfactory behavior had been noticed, or whether it was because she discovered there could be consequences for it. The over-all result of this incident seemed to have a beneficial effect, since the complaints implied the expectation that she could do better.

Up to the present, although the therapist has heard some about work activities, there has been a marked dearth in information about other aspects of her living. The therapist usually hears about events weeks or months after they happen. Occasionally the patient mentions feeling embarrassed about what the landlady will think if she has no engagements on a week-end. It is obvious that she has social engagements with boys and girls, but she reports practically no details about them to the therapist. The therapist has called this to the patient's attention.

The patient began to go to college at night twice a week, taking courses in English, French, and art, and later psychology. Her grades were good. At the change of semester, her motivation in selection of courses was not always clear. It appeared to be based partly on the renown of the instructor, partly on whether she could be comfortable with

the instructor. She gave more consideration to the selection of male instructors. At various times she has thought she would give up college altogether and it has usually revolved around her feeling of discomfort with the instructor. Sometimes she has a feeling of uneasiness with other students. When she began to date one of the male students, she became extremely uncomfortable; when he began to move in too fast for her comfort, she seemed not to know how to deal with it. She seemed to have had real benefit from the psychology course and remarked with surprise that the instructor and the books said many things that the therapist had said.

In discussing her college work, the therapist and the patient were led into the question of the patient's complaints about college, which had a more genuine and legitimate quality of dissatisfaction than some of the patient's other complaints. The patient began to feel that the other students were able to get implications that she was unable to get. (She was still collecting data without being able to integrate.) This opened the question of what it was that she "was not supposed to know." In her earlier life father had warned her not to tell people his occupation. Mother had not answered her questions about sex, and father had made it clear that women should not have any interest in such matters. The therapist began by asking her what it was she was "not supposed to know." But when the question was reworded: "What is it that you know that you are not supposed to know?" the patient was able to answer with more

emotion. The patient seemed relieved when the therapist, in a matter-of-fact way, assumed that the patient was fairly sophisticated in her knowledge. (Perhaps there was a shift here in the transference situation since the therapist did not naively believe in the patient's innocence like the father did.)

In recalling childhood experiences, the patient said that she was not on good terms with her older brother from early childhood. He and the other brothers were granted much more freedom by the father. They were allowed to join the scouts, and she was forbidden. If there was a dispute about radio programs, however, the father decided in favor of the patient; and he offered her the last cookie, and so on. When father was not at home, mother did not show the same preference for the patient, so the patient felt that father cared for her and mother preferred the boys. However, she felt that although father loved her, he was not dependable, because he frequently promised to bring things to her and forgot to do it. She was puzzled by the difference in treatment accorded her brothers and herself, not only as a difference in what boys and girls are allowed to do, but also because there were occasional times when the family was visiting when she found out that other girls could do things that she was not permitted to do. When things displeased her, and she retired to her room, her mother did nothing about it, but her father would coax and cajole her to come downstairs. She was usually won over when father would bring food.

Jane and her father had in common an appreciation of good music and good food. The mother rarely found acceptable the restaurants or kinds of food that Jane and her father selected, and the mother never enjoyed her own selections of food at restaurants.

The patient recalls that her mother, on their occasional trips to town, would ask if she would like an ice cream soda or some sweets. These times were deeply significant to the patient because it was clear that this was being done for her. This was definitely in contrast to father's way of doing, because if he made such a suggestion, it was because he wanted something himself, and the patient got it only because she happened to be there.

During the course of the work it became clear that the patient was quite dependent on her father for her physical health, and on her mother for routine care. Mother had a reputation for soundness of judgment in selection of clothes, and so on, and for thriftiness. She was considered invariably right about such matters as social conventions, fashions, the "right" people (the janitor's daughter was not acceptable), and the "correct thing." Mother was necessary because of her magical know-how, although she had no enthusiasm and never gave signs of enjoying life.

One of the frustrating characteristics of the mother for the patient was her apparent inability to show emotion. As the patient saw her, she

seemed to have no needs. She was unperturbed by her husband's hate and fury--she seemed to be able to stand anything. Not only did she seem to have no feelings, but she appeared to take a dim view of anyone who did. The patient recalls that when father would start to put his arm around mother occasionally, mother looked uneasy and discouraged it. This emphasized to the patient how unlike her mother she was, in the area of emotions and feeling, in addition to her competence in judging people, social conventions, and so on.

The data about the patient's sexual experiences came late in the work, and it was obviously difficult for her to talk about them. When the family first moved to Baltimore, she shared the bed with her parents, and the father evinced considerable concern about her falling out of bed. At the age of three she came upon her parents having intercourse, and her father screamed at her to get out. She recalls that her mother lay very placidly in the bed, and her thought at the time was that her father was hurting her mother. In the early years it was customary for her to shower in the bathroom with her father and brothers, but she never did this with her mother. The patient was aware that her mother was uneasy when the patient saw her partially dressed. When the patient wandered naked into her mother's room, her mother asked if she had no shame. The father came upon her a various times while she was masturbating and was decidedly against it. She remembers asking her

mother for information about sex, and her mother's uneasily referring her to father. However, she did not ask father. On one occasion, when she was around seven years old and her parents were out, her older brother asked to look at her genitals. She recalls her feeling as one of surprise, but she granted the request. This was the only such experience with the brothers.

The patient seems to have had limited sexual experience. She apparently had had some intimacy with a young man which precipitated the present treatment. He had been engaged to marry another girl, and apparently the patient had agreed to some intimacy with the hope of winning him from the other girl.

During the early work with the present therapist she showed real concern about some photographs of herself in the nude taken by a young man. Her worry was about how he might use the photographs.

After the treatment had been going on for some time, the patient mentioned that her father was depressed about another job situation. The therapist asked if the patient would like to have her father come to see the therapist, and she agreed, but was doubtful whether he would come. However, the father telephoned and reluctantly agreed to come. When he came, the therapist realized that he thought he had been summoned to talk about his daughter. When the therapist pointed out her purpose, he was not angry, and took her suggestion that he get

treatment with a rather hopeless attitude that nothing could be done for him.

The patient seemed relieved that the interview with her father had gone favorably. It was obvious to her that the father was quite pleased with the therapist for her interest in his welfare. Undoubtedly this incident was significant in the transference since it showed that the therapist could be interested in a person like her father, and was not afraid of her father. Since the father's spirits improved, the patient's troubles were lessened. There was an absence of his usual criticism about women.

Present Status:

At the present time the patient is continuing in treatment. She has shown a slow but consistent improvement, with one major depressive episode during treatment (the suicidal attempt mentioned earlier) and a number of less severe fluctuations in mood.

In recent months the patient has been able to discuss some of her reactions to the therapist. For instance, the therapist's mode of dress has been a recurrent problem to her. On the one hand, it did not fit her standards of prestige; on the other, the therapist's lack of concern at her criticism impressed her with the beginning realization that dress might not be all-important for social success or failure. This was particularly noteworthy on one occasion when the therapist wore

bedroom slippers. In addition to her oversensitive and critical attitudes, the patient showed a lively concern on those occasions when the therapist dressed up. And this reminded her of the uneasiness she had experienced earlier when her mother, in similar situations, had aroused her father's anger. It seemed that the patient was concerned lest the therapist be too interested in "wrong" things, which might detract from her interest in the patient. Also, the patient seemed to need to be watchful of the therapist, as she had been with her mother for her father's sake.

A variety of similar incidents occurred, such as the patient's inspecting the therapist's appointment book, and the patient's noticing with astonishment that her therapist could take an interest in politics on an occasion when the therapist made a remark about a political discussion.

She began to achieve greater confidence about her physical strength and health, and as she did so, her dependency on her father lessened. She was able to arrange her own appointments when she needed medical help, and on a vacation trip home in the summer of 1952 she began to feel "finished" with her parents. She was able to observe a number of their real inadequacies, such as her mother's prudish refusal to talk about her sister-in-law's pregnancy. However, she also felt quite disturbed when she noticed that her parents had a better

relationship with each other.

She had a similar mixture of feelings about her therapist. When the therapist left on a two-month vacation, her spirits skyrocketed, as though she were out of school now and could do as she pleased. After about two weeks, she became quite uncertain at work and felt as though, in her mounting excitement, she was not sure of what she might say or do. Coincidentally, she developed a severe backache and decided to go home and get attention for her back. When she arrived home, she felt better and the backache soon improved. However, it returned again when she returned to Washington, only to fade out for good as soon as the therapist resumed work with her. When she resumed her therapy, she complained that she did not feel as positive to the therapist as before, but she has since talked more freely and has come nearer to dealing with current difficulties as they arise.

In recent months, her ability to handle a difficult relationship at work has been much improved. When one of the other girls offended her by making a disparaging remark about Jews, the patient withdrew from the association, but became concerned with how she would be able to handle necessary encounters with the girl in the future. After discussion of it with the therapist, she was able to deal with the situation with a few appropriate words. As she has expressed it, she is just beginning to discover that other people are really there.

Case 3: Mr. H

This patient is included because he illustrates some of the problems of borderline conditions between manic-depressive psychosis and schizophrenia. He has had a series of manic attacks throughout his lifetime, beginning at the age of seventeen, but he has never had a major depression. The manic attacks, while being characteristic in their onset and in their self-limited duration, are also accompanied by some dissociative phenomena which are particularly evident when the mania is at its peak. The patient develops a fairly well systematized delusion, grandiose in character, about there being a plan on the part of some powerful persons to build him up and make him famous. This system is elaborated and acted on in the sense that the patient tries to make his environment cooperate in bringing the plan to fruition. His disturbance reaches a pitch where hospitalization is required, and then, as his excitement increases, he tends to become more disorganized, to give up the elaborate system, and to regress into destructive and untidy behavior. During this period, he may spend several weeks in a seclusion room, singing, talking incoherently, and at times smearing feces. There are no obvious hallucinatory experiences; the picture is more one of disorganization. Following the disorganized period, which lasts only a few weeks, there is a quick reintegration with a resumption of hypomanic behavior. The behavior then gradually comes down to its

usual level. The patient experiences a few weeks in which he has feelings of weakness and depression, and then is able to resume normal living, until the next attack.

General Description.

The patient started treatment in 1946, at which time he was 36 years old. He is a lawyer of Jewish origin, and a widower. He is a large man, 6'2", weighing approximately 200 pounds. He has an open, friendly, extraverted manner. He is normally quite talkative, uses a great deal of humor, and at times is quite smart-alecky and mischievous. Characteristically, during his periods of mental health, he avoids introspection and is unable to communicate with others in terms of discussing feelings. His tendency is toward action; when he discovers a feeling within himself, or in someone else, his habitual response is to seek for something that can be done about it. He is rather efficient in carrying out the business of living. He is meticulously neat--indeed, almost fanatically so--and has a number of superstitions about health which he carries out in compulsive fashion. For instance, he believes that the nasal passages require washing out daily in order to maintain health, and becomes frustrated if he is unable to carry out such a procedure. He also has fixed ideas regarding constipation, and so on.

He is a man who knows a great many people, and is particularly interested in the important ones, in a prestige sense. He tends to

exaggerate his intimacy with prestige figures, particularly, of course, during his periods of excitement. He has, however, no male intimates, and his intimate female friends change from year to year. The manic attacks are closely related to his difficulties with women. He establishes an intimate relationship, seeks marriage, and becomes increasingly forceful and domineering toward the woman, trying to force an immediate marriage. Usually the woman becomes apprehensive and attempts to withdraw, and, at this point, his manic attack breaks out. He becomes extremely aggressive toward the woman until the police have to be called to remove him from her doorstep, and quite promptly thereafter he requires hospitalization. It is rather remarkable, in the light of his way of handling relationships, that he continues to inspire in many of his male acquaintances a long-standing affection. A number of these friends have retained a rather notable degree of tender feeling for him throughout numerous illnesses, in spite of the fact that during the illnesses they are bombarded with telephone calls, are subpoenaed for sanity hearings, and, in general, are put through a good deal of inconvenience. His relationships with women do not show this same kind of durability. Having broken off with one of his intimate women friends, he never resumes the relationship. The patient also has a marked preference for a variety of such masculine pursuits as betting on the races and gambling. He is extremely successful as a bridge and

poker player and carries on a set of durable relationships with gambling friends which last through the years. A similar group of acquaintances participate with him in athletics, particularly tennis playing and handball, at both of which he is an expert. Each set of activities carries with it its own group of acquaintances, and none of these relationships develop into what is usually considered to be a close friendship.

Family Background.

The patient was born and raised in a large Eastern city. The parents are of Jewish immigrant stock, both having been born in this country. Both the paternal and maternal families lived in the same city, and there were numerous uncles, aunts, and cousins growing up in the same region. There was a great deal of competition between the parents and their brothers and sisters regarding money, prestige, and the promise of their respective children. One family in particular, who were cousins of the patient's parents, made a rather spectacular financial success, and were the objects of great envy on the part of the parents. The father was a doctor who was quite unsuccessful in his profession. During the early years of the patient's life, he carried on a private practice, and, in addition, owned a drugstore and a number of pieces of real estate, which brought in a nice income. He found private practice distasteful, and let his practice go to seed. This was resented terrifically by the patient's mother, who nagged and quarreled with the

father incessantly. The mother felt that professional dignity was highly desirable. When the father started neglecting his private practice, she became unbearably resentful. There were frequent quarrels, particularly in the morning in the bedroom, when the father would refuse to get up in order to go tend to his patients. As the mother nagged, the father would pull the bedclothes over his head and withdraw from the scene. At times there would be patients waiting in the waiting room downstairs, while the father lay in bed in the mornings. Eventually the father gave up his private practice and ran the drugstore full time. However, during the Depression, he lost the drugstore and then was forced to go back into the practice of medicine. He then worked for the school system in a poorly paid job, which was, again, a source of shame to the patient's mother.

The father was a gentle, friendly, sociable, unambitious, likeable person who was idealized by the patient. He was, like the patient, "one of the boys." He loved to play billiards and card games with his male companions. He used to take the patient out with him on his social engagements. Also, the patient used to spend a great deal of time with the father in the drugstore, talking to the salesmen and showing off his precocious intelligence in order to please his father. The father had a great many hypochondriacal preoccupations. He had chronic sinusitis, which he treated by washing out his nose daily. Eventually he contracted

a middle-ear infection, which resulted in a brain abscess, from which he died. At the time of the father's death the patient was 21 years old.

The mother, who was of immigrant Hungarian Jewish stock, came from a family of somewhat lower social and economic status than that of the father. She married the father when she was sixteen, largely because she was unhappy at home. The patient was born when she was seventeen. After the first few years, the marriage became increasingly unsuccessful. The nagging criticism of the mother, together with the passive resistance of the father, became a pattern which grew increasingly prominent. The mother used to engage in long tirades against the father; sometimes he would lie in bed without replying, and sometimes he would leave the house to join his men friends. The mother was extremely wrapped up in the need for social prestige. This was more important to her than economic success. The patient was somewhat over-protected in his early years; for instance, he was dressed in Buster Brown suits when his contemporaries were allowed to wear play clothes. The mother also exercised very severe control over him in demanding good behavior. The patient strongly identified with his father, and avoided his mother when he could. However, she was considered to be the dependable one of the family by him, and he did turn to her when in trouble, expecting and receiving assistance. After the father's death, the mother established a small business from which she earned enough

to support herself. The mother continues even now to let the patient exploit her and then engages in long tirades against him for his selfishness and irresponsibility. She is an extremely irritable and dissatisfied woman who feels that she had a very raw deal from life.

The patient has one sibling, a brother five years the patient's junior, who is a successful lawyer. He is a hard-driving, overconscientious, tense person who is his mother's right-hand man. He, too, permits the patient to exploit him and is openly resentful even while he is doing it.

Developmental History.

Nothing is known of the patient's infantile history. By the time he was four, he was exceedingly precocious intellectually; he was able then to read and could do complicated problems in mental arithmetic. He was greatly encouraged to show off his skills to his grandparents, his cousins, and to the salesmen who came to his father's drugstore, so that the patient was frequently the center of attention. He was precocious in school, graduating from high school at the age of fifteen. Some of his patterns of interaction with others became conspicuous during the high school years. He tended to attach himself to the prominent boys in the class, playing a somewhat sycophantic and satellite role with them, and gaining by the political spoils which his "men" could hand out to him.

During his summers at camp, he strove to gain recognition by being skillful at tennis and was deeply wounded when other boys received medals as the best-all-around campers, while he was passed by. He felt that his skill at games should bring him this recognition and was unable to see that his inability to cooperate and his need to play the starring role were handicaps. His tennis skill was such that he was one of the best junior players in the city, a fact which gave him entree to the exclusive country club, and this became a source of needed prestige to him.

He was late in developing heterosexual interests. During his teens there was a great deal of emphasis on his mother's part on the desirability of his marrying a girl of good family. This apparently resulted in his tending to avoid the company of girls.

His first illness occurred at seventeen. He was in his second year of college and apparently suffered from rather severe disappointment in failing to be put on the varsity tennis team. This was followed by a period of overactivity during which he fantasied that Bill Tilden was watching over him as a future member of the Davis Cup Team.. This illness reached a critical point around New Year's. He was intensely excited and believed he was going to die on New Year's Day. Following the crisis he made a rather quick recovery, returned to school, and finished college and law school. His last year of law school was

marred by the prestige competition for honors and by his worry over the prospects of a job. Many of his classmates received appointments as juniors in various law firms in the city. The patient did not, and felt extremely hurt and envious of those who did. He rationalized this lack of recognition as being the result of anti-Semitism. At the time of his graduation from law school, his father died, and this precipitated a second psychotic episode. Upon recovery from this, he came to Washington, where he began working for various Government agencies. He had his third and fourth manic attacks in 1934 and 1935, while he was working for the Government.

In the spring of 1937, while on a trip to Florida, he met and fell in love with his future wife. They became engaged on the first evening of their meeting, and were married the following fall. The probability is that at the time the patient met her, he was hypomanic. He remained well until 1939, when friction developed with his employers and with his wife's family. Another psychotic episode occurred in March of 1939, and again in 1940. His wife left him at the time of his illness in 1940. The patient quit his job and went to New York to act as volunteer campaign manager for Wendell Wilkie in his campaign for the Presidency. At this time, he had the delusion that, in return for his services, he would then be groomed as the next President. This period of excitement in New York was not followed by hospitalization, but when his excitement

quieted down, the patient returned to his Government job. His wife's death from leukemia occurred during the period he was manic. The patient remained well, working in his Government job, until 1941, at which time he was hospitalized again and received shock treatment. There was again a period of health until 1944, when he was again hospitalized and received shock treatment. Again he remained well until 1946, when hospitalization was necessary. Following this period of illness, he came for psychoanalytic treatment.

Course in Treatment.

Upon entering treatment, the patient's formulation of his need for psychiatric assistance was that it was to be a form of insurance to keep him from getting sick again. He personally did not feel that his manic attacks had an emotional cause. It seemed to him more likely that they were seasonal or had some physical origin, but he had been advised to give psychotherapy a trial. He had had some rather superficial therapy previously, which was largely oriented toward educating him to recognize the prodromal symptoms of his manic attacks, so that he would be able to get away for a rest before the condition became too severe. This educative attempt had proved to be a failure. The patient had become the social acquaintance of his former psychiatrist who had then become a sort of friend rather than a therapist. At this time, too, he was without a job. His Government employment had been terminated

during his last illness. He now was receiving an allowance from his brother, and intended to set up in private practice of law as a way of earning a living. He had rented desk space in the office of another lawyer for this purpose. While waiting for clients, he supported himself by his winnings at bridge and poker, together with his salary from a part-time teaching job.

At the time of the initial interview, the patient was somewhat below par mentally, feeling rather depressed, discouraged, and fatigued. He attributed most of his depression to physical effects from the strenuous experiences he had had in the mental hospital, and his need was felt as a need for rest. Most notable at this time was the patient's tremendous inarticulateness about his feelings. Everything was presented in terms of concrete objective reality, such as fatigue or physical symptoms, and he implied that psychotherapy was foolish with its talk about emotions. The field of emotions was, so to speak, a feminine or childish territory, whereas the masculine or competent person dealt in terms of facts.

He was breezy, rather smart-alecky, and quickly initiated the practice of referring to me by my first name. He also made efforts to become a member of the household, since my office is located in my home. He made free use of the telephone, which necessitated his going upstairs to the living quarters. After he had received permission once

to use the telephone, he took it for granted and thereafter used the telephone without asking again. He also formed the habit of entering my office to wait for me, on those occasions when the office was not occupied by a patient prior to him. He showed rather severe signs of guilt feelings over these practices, but the experiencing of guilt feelings did not cause him to give them up. He continued the practices and continued feeling guilty about them.

At this time I did not attempt to set limits for him, as far as what would be acceptable behavior was concerned. I was more oriented toward working on the guilt feelings with him, and therefore ignored my resentment at his overbearing ways and in this way implied that his use of the telephone and occupancy of my office were acceptable. This started a trend which became increasingly unhealthy during the course of treatment; as he continued in treatment, the number of exploitative acts increased and with them my resentment increased. However, since I had taken the position that this behavior was acceptable, I found myself unable to call a halt to his behavior, feeling that, for the sake of consistency, I must stick to my original position. Two occurrences brought an end to this pattern of interaction between us. One of them was his reading of a private letter of mine during one of the periods when he waited in the office. The other was an incident in which, as he came to the office for his hour, he stopped on the walk which was just outside the windows

of my office, to open the windows in the office, at a time when I was seeing another patient. He explained that he wanted to open the windows in order to permit the smoke in the room to escape before he came in. His previous exploitative behavior had been accepted at least in silence by me, although not without resentment, but I became very angry at the last episode and reproved him sharply and coldly. He showed a rather remarkable response to this rebuff, in the sense that he was utterly taken aback, wilted rather dramatically, apologized, and then put the matter out of awareness. However, though he rather quickly became inattentive to the incident and unaware of his feeling-response to it, it had a rather profound effect on his behavior. He showed an increasing uneasiness with me, and a withdrawal from what little spontaneity and intimacy he had been able to achieve. This episode was brought up twice again by me for discussion because of my belief that it had had a profound effect on him. However, the severe anxiety which he experienced at being reproved was not uncovered and therefore not resolved.

His next manic attack followed this episode by only a few weeks (June 1948). The transference-countertransference difficulties which are illustrated by this episode may not have actually been causative in producing the next manic attack but could have been of sufficient significance to account for our inability to avert it. The period of treatment which went on prior to his manic attack covered about a year and a half.

In retrospect, it seemed that his mood had been rising and his behavior had been growing somewhat more erratic for several months--possibly since Christmas time.

This was not apparent at the time. Other events which, in looking back, appear to have been early signs of increasing manic behavior were as follows: The patient had an office arrangement in which he rented a small cubbyhole in a suite occupied by some lawyer acquaintances. He was quite resentful of his poor housing accommodations, particularly because the room was very cold during the winter months. He felt that he was being overcharged for rent, and when he was asked to pay half of the cost of the rug for his room, he felt this was highly unjust, although he said nothing about his feelings to his office mates. Apparently he revenged himself somewhat for this maltreatment by occupying the office library during much of the working day, instead of using his own room, and by making telephone calls in the library, which were then charged to the other lawyers' telephone bill instead of his own. The other lawyers in the suite began planning to rent out some other space to two more lawyers, which occasioned again considerable resentment in the patient, because he felt that the additional tenants would encroach upon his occupancy of the library. He suddenly learned at this time that there was a building for sale which would provide good office accommodations for a number of lawyers, and he began quite energetically to pursue the goal

of getting a group together to purchase the building and establish offices. He was successful in interesting a group of men in doing this. Then came the question of making his contribution to the downpayment. He had no resources himself, so he made a trip to Philadelphia where he persuaded his mother to lend him the money for his share of the downpayment. There was a terrific battle between them before she gave in, and she expressed extreme bitterness to him at the way in which he was exploiting her, while, at the same time, she grudgingly agreed to provide the money. The patient was the active agent in the whole planning and organizing of this enterprise, which involved a great deal of manipulation in order to make financial arrangements with the owner of the building so that a very small downpayment would be acceptable. The arrangements were completed and the group moved in together. The patient, of course, still had no law practice. There was an occasional client, with an occasional small fee, but the amount he earned from his clients did not even take care of his share of the rent. This project was no sooner completed than the patient was laid off from his teaching job, which had been his only source of steady income. He was told that the enrollment at the school was small during the last semester of the year. Whether the quality of his teaching had deteriorated, or his emotional tension had created difficulties for him at the job, was never clear. The patient then was in an increasingly insecure financial position, being forced to

rely entirely on his allowance from his brother and on his income from gambling, to meet his expenses. At this period he then became emotionally involved with three women in rapid succession. The first two intense involvements lasted only for a period of weeks, because the women did not participate. The third involvement was with a young woman who rather seriously considered marrying the patient. He attempted to persuade her to elope with him during the first week of their acquaintance. When she hesitated and held back, his controls broke down completely and within a week's time he was sufficiently disturbed to require hospitalization. In dealing with his mother, with his girl friend, and with myself, during this period in the spring of 1948, the patient's behavior was quite different from his usual style. He was intensely aggressive, demanding, and exploitative. When his requests were not met, he showed a mixture of intense rage and childish petulance. This was considerably less apparent with me than with either of the other two women. He seemed to be too much in awe of me to exhibit the full strength of his demandingness and resentfulness. Up until the last week before his hospitalization, his behavior had remained within conventional limits, to the extent that both I and also the others in his environment were unaware of the impending psychosis. The psychotic behavior came on with startling suddenness, practically overnight. He came to my office on a Sunday for an extra hour, laid down on the couch and said,

"I am sick. Send me to a hospital." He demanded that I feed him at this time, asking first for a glass of beer and then accepting a Coca-Cola. He made this demand in terms of its being a test of our relationship. During the period that he remained in the office while hospitalization was being arranged, he showed short periods of extreme hostility and threatening behavior, which would quickly give way to feelings of extreme weakness, during which he was too weak to raise his arm.

He was admitted to a hospital the same day and from then on rapidly became more and more disturbed. He engaged in a daydream of having a special regimen planned for him, which would include building him up physically, getting Bill Tilden to come to the hospital to practice tennis with him, and then, when he was built up, being sent around the country to play exhibition tennis matches and be an emissary for peace. This fantasy alternated with another which amounted to a formula for how to get along in the world. This he expressed as, "Love your father; love your brother; hate your mother; kill everybody else in the world." Management of him at the hospital was extremely difficult. He manipulated all the rest of the patients, as well as the personnel when they did not obey his orders, and eventually required isolation for several weeks. During this time he was nude part of the time, smearing feces. The hospitalization lasted about two months.

Following his discharge, his behavior was still disturbed so that he required another hospitalization which lasted less than a month. Following this, he was somewhat subdued and depressed, fatigued, discouraged, and extremely insecure about the future.

The outstanding therapeutic problem during this period was that of getting the patient to think in terms of "psychic causality"; that is, to recognize that there was a connection between what he experienced in his dealings with others and the way he felt. He was unable to recognize, for instance, that when someone did something to slight him, this would lead to his having hurt feelings. His feeling-response to the happenings of his life was out of awareness. This can be illustrated by an incident: He was doing some part-time teaching in a night law school, and at Christmas time the students gave presents to the various members of the faculty. Since the patient had been a faculty member for only a very short time, he received a small present, a necktie, while some of the other teachers received much more magnificent ones. Following this event, the patient came to his hour and complained of not feeling well. As he went through his account of the happenings of his life during the previous few days, the fact that he had received a Christmas present was mentioned. He did not, however, mention any comparison between the size of his gift and that of others, or any feeling of being wounded that he had not received a finer gift. Largely by chance, I inquired in

more detail about the Christmas giving at this school, and as I did so, I heard the full story. It was still not apparent to the patient that he had felt hurt and did not become apparent to him until I asked him whether he had felt hurt. When I asked the question, he then realized that he had been hurt. He was then able to go on and see that his feeling of depression had been initiated by this episode. However, without actually having his feeling experience identified for him and named by me, he was unable spontaneously to recognize it. This blindness regarding his own feelings was an outstanding difficulty in treatment, which did not yield to repeated working through of similar episodes. With each new episode, he remained unable to recognize what had actually happened in the area of his feelings. It eventually became apparent that this had something to do with his notion of how he ought to be. If, for instance, he believed that he ought not to feel hurt or that he ought not to feel angry, he was unable to feel hurt or angry. In fact, his entire orientation in living was an effort to discover first how he ought to feel and second to get himself to feel the way he ought to. This meant that I was used as a guide. He attempted to pick up cues from me regarding how he ought to feel and how he ought to behave, and having picked up what he identified as a cue, he then would set about conforming with what he believed I expected.

Following his discharge from the hospital, the patient continued

psychotherapy with me. At this time he was depressed and discouraged. He again felt depleted physically and required some weeks to regain a feeling of physical well-being. His aim to establish himself in law practice was given up, and he began looking for a job, finally securing one in a Government agency through the good offices of an old friend.

During this period of treatment, virtually no real therapeutic progress was made. The work focused around the patient's reality problems, such as his difficulties in securing a job, and his relationship with his girl. I was seen by him as an agent--a source of advice in how to secure a position or persuade his girl friend to marry him. His efforts were directed toward inducing me to intercede on his behalf with his girl friend. My refusal to act for him was met with resentment, and he never stopped feeling that his requests were reasonable and my non-co-operation blameable. His line of thought was that I would have been able to persuade his girl to marry him, and since I refused, his disappointment was obviously my fault. While he had been in the hospital, his girl had begun analysis herself, and as her analytic work went along, she discontinued her relationship with the patient. When the rejection was finally made, the patient accepted it with apparent grace.

Despite this disappointment, he continued to get along adequately. He expanded his social activities somewhat, made an effort to cultivate some friends and to increase the range of his interests. By the summer

of 1950 he began to feel that he no longer needed regular treatment, believing, as usual, that his manic attacks were now a thing of the past. I concurred in his wish to discontinue treatment, largely because of my discouragement about the usefulness of treatment to him. This decision of mine was reinforced by my resentment of the patient's exploitative behavior and inability to use my analytic efforts for any sound and constructive change. Regular interviews were discontinued in July.

The patient left on vacation in August and before the end of his vacation period was in the throes of another psychotic episode. Again, there was an intense involvement with a young woman. This time there was actually no sound basis for a relationship between the two and the patient's involvement was largely fantastic. His efforts to induce the girl to marry him reached outlandish proportions. The girl's mother attempted to protect her from the patient's intrusion and the patient went to the police, then to the White House, and finally to the Supreme Court, demanding a writ of habeas corpus to prevent the mother from keeping his girl away from him. Hospitalization this time was arranged following the patient's arrest for disturbing the peace. He remained in the hospital for a longer period than usual, approximately four months. On his discharge he resumed his previous employment, but did not come back for treatment. He made some tentative approaches to me. Although his approach to me was partially a request for treatment, it was also

partially an expression of extreme hostility and recrimination against me for having deserted him. I did not encourage his resumption of treatment, so he went back to see his old psychiatrist in a nearby city from time to time, and otherwise got along on his own. He remained well about a year and in January of 1951 again required hospitalization. At this time there was another intense emotional involvement with a woman. This time the woman was the pursuer, being very strongly attracted to the patient. She was in analysis herself, separated from her husband, suffering from chronic depressive feelings, and apparently found in the patient something which met her emotional needs. There was no possibility of marriage, since she was not yet divorced and the relationship was apparently interrupted by the patient's becoming psychotic again. Hospitalization again lasted somewhat longer than his average. He remained in the hospital from January until June. During this time his friend, Mrs. J, remained interested in him, visited him regularly, and indicated her willingness to marry him if and when her divorce was put through.

On his discharge, the patient again returned to therapy with me. He seemed somewhat more seriously inclined to try to examine his behavior from a psychological point of view, and this motivation on his part was reinforced by his wish to succeed in his relationship with Mrs. J. Also, some weight must be given to the pressure she brought to

bear on him to resume therapy. I accepted him for further therapy for two reasons: first, I wished to use him for study in the present project, and second, I had developed some theories about techniques of treatment with manics which I wished to try out with him. I believed that the long-standing grudges which we held against each other would have to be resolved in order for therapy to have a chance to succeed. Accordingly, I brought them up in our initial interview, both in terms of the past and also in terms of the future--that is, what kind of behavior would be acceptable to me. The discussion was beneficial in so far as my feelings of resentment were concerned. I felt able to continue treatment subsequently without particular tension. The patient reacted with considerable bitterness but seemed also to acquiesce in the redefinition of our relationship. The redefinition could be described as my having laid down certain rules of behavior, chiefly that his exploitative acting out was unacceptable, and that these impulses should be verbalized and analyzed. The patient immediately conformed to the "new rule" about not trying to exploit me. However, the efforts to bring this type of material into discussion in the therapy were quite unsuccessful. Instead, the patient's dependent and exploitative drives were deflected into his relationship with Mrs. J.

During the fall and winter, under his pressure, she arranged for her divorce and they began to plan seriously on marriage as soon as the papers were final, which would have been early in January of 1953.

Mrs. J. had two adolescent daughters, both of whom were problems, and the proposal was that in marrying her, the patient would be taking on partial responsibility for them, as well as for Mrs. J. He had been playing an extremely active role in pushing the divorce and in making the practical arrangements for the marriage. Mrs. J. seemed to feel too depressed and lethargic to get her own divorce and therefore welcomed the patient's pressure.

The patient also was playing a very active role in fathering the girls and in disciplining them and insisting on a better level of behavior from them than their mother was able to elicit. Just a few days before the wedding, he suddenly became extremely resentful of the lackadaisical behavior of Mrs. J. and the laziness of the girls. He felt that he was being made to carry the whole burden of the household, that the others were exploiting him and, by using sergeant-major tactics, he attempted to force Mrs. J. and the girls to change their sloppy ways. His aggressiveness toward them was ineffectual in remedying his grievances, and again within three days his behavior had reached psychotic proportions and hospitalization was necessary. Six months later, he was again well and the wedding was accomplished.

Psychopathology.

The main factors in the patient's psychopathology may be formulated as follows: The patient is primarily concerned with succeeding

in an exploitative way of life. His fantasy is that in return for being a good boy some figure of strength and prestige will take care of him. The care involves having his material success assured and rising to a position of great prestige. The fantasy does not envision an intimate relationship of love and tenderness, and the magic sponsor is thought of as being a man. In addition to the fame and fortune which would be provided, the patient also desires to have a wife who would give him companionship and take care of him physically.

He suffers from extreme feelings of envy toward his male contemporaries who have been more successful than he. The envy is so acute and painful that it is for the most part kept out of awareness. It occasionally forces itself upon his attention, particularly at times when some one of his contemporaries has received a promotion or other sign of success. The patient always feels that he deserves the promotion more than the other person and believes that his illnesses are the stumbling block in the way of his receiving it, or, at times, that the lack of recognition is due to anti-Semitism. While he is an extremely intelligent and able person who does his work adequately, except in periods of emotional disturbance, he has never visualized himself as succeeding on the basis of his productivity, and he has never made an effort to succeed on the basis of doing a better job than his competitors. His efforts toward success have always been directed toward getting to

be the friend of the boss, becoming a companion of the boss in sports or games, or going to the races with the boss. By getting the boss to like him especially or find him pleasant and agreeable to be with, he hopes to interest the boss in promoting his future. During the psychotic episodes this pattern increases in its scope and becomes a grandiose fantasy in which he is being groomed for the Presidency of the United States or in which the eye of some mysterious person is watching over him. He said, for instance, "There is an organization, the F.B.I., which is set up to find the bad people and put them where they can't do any harm. Why should there not be a similar organization which has been set up to find the good people and see to it that they are put in a position of importance?" He, being one of the good people, would be an object of attention for this second organization.

By looking back into the patient's childhood, one can see some of the origins of this pattern. There was, of course, the example of his father who was universally liked as being a good sport by the men of his circle, who did not succeed as far as productive work in his own profession went, and who was, in the patient's eyes, always a great humanitarian whose failure in life was due to the lack of appreciation of others rather than due to any defect in himself. The patient received much prestige and praise from the adults around him for his precocious intellectual development, and his ability to show off in front of both his

relatives and his father's companions. The grandparents adored him because he was able to read their Hungarian newspapers to them when he was a very little boy. They spoiled him with attention and adoration and the grandmother particularly fed him tidbits as a means of expressing her affection. The patient quite frequently would go to his grandmother's house to be fed, going there for lunch on school days and for snacks in the afternoon or evening. Apparently, then, winning praise from adults was the satisfaction which took the place of tenderness and affection for the patient. As long as he was a good and precocious little boy, he was able to succeed with grownups. However, this was a very ineffective technique in getting along with contemporaries, and the patient was actually almost totally unable to form an equal give-and-take relationship with boys his age. Of course, this was partly contributed to by the fact that he was three years younger than his schoolmates. His envy was particularly notable toward the boys among his age group who were successful on the basis of their own efforts, rather than on the basis of their success in pleasing grownups. One particularly sharp example of this occurred just before the patient's first psychotic episode. He had apparently been rather nervous and was sent back to his old camp the summer he was seventeen. His brother was a first-year camper that same summer and before the season was over, his brother had been given the camp honor medal, an achievement which

the patient had never succeeded in accomplishing. This type of experience precipitated in the patient an almost unbearable feeling of envy which was so severe as to require repression. This same type of unbearable envy has continued throughout the years as men of his own age and status have moved ahead and he has remained behind. He continues to use the same technique for trying to achieve success, despite his present intellectual grasp of its inadequacy. One of the events bearing upon his present manic attack may well be the fact that in his agency there is a vacant position in the next grade above his. The patient is intensely desirous of receiving this promotion, but is quite fully aware that his chances are extremely poor because of his erratic employment record. The situation at work is sufficiently tense so that his boss has avoided selecting anyone to fill the vacancy, knowing that the patient desires it and being unwilling to give it to him.

In the treatment situation, the feelings of envy have been quite intense as far as comparisons with me are concerned. He envies my material success, my home, my car, my prestige. In this respect, I apparently have masculine attributes as far as he is concerned. These envious feelings are not directed ordinarily toward women, although they are directed toward the material possessions of the women he knows. In his earlier romance with the woman who rejected him after beginning her own analysis, the fact that she owned an automobile,

which he did not at the time, was of tremendous significance to him; in fact, at times I wondered whether his interest in marrying her was not chiefly a matter of gaining possession of the car.

However, in general, women have a somewhat different significance to him. He has less respect and less real interest in women for companionship or intimate exchange of thoughts and feelings. They tend, in general, to be to him a source of food in all its aspects--that is, his desire is that a woman make him comfortable, that she be with him in order to keep him from feeling lonely, that she take care of him in order to prevent his being hungry, that she sleep with him in order to prevent his being in sexual need, and so on. This pattern has shown some change in the course of treatment. His last relationship, with Mrs. J, has been the best relationship he has ever had with a woman from the point of view of sharing thoughts and feelings and giving the things that go with an intimate relationship. This is largely to be attributed to the character of Mrs. J who makes this sort of demand on the patient. However, the fact that the patient has been able to meet her wishes and demands in this area would seem to indicate some change in his own character. The basic problem, the exploitative way of life, has never been solved by the patient. While he has a partial intellectual grasp of it, his intense infantile dependent needs have remained of such a degree that his intellectual understanding has, as yet, been of little

or no use to him. The history of his transference relationship with me reveals this pattern very graphically. It has been something which, as his therapist, I have not succeeded in handling. Earlier in this report, the exploitative relationship was described as it first developed with me. At that time it can be seen that I was participating in the exploitation by, on the one hand, permitting it and, on the other hand, not actually recognizing its significance. This is a particular problem in the treatment of a manic. The analyst is accustomed with other patients to play a rather passive and nondirective role which, when carried out with the manic, inevitably brings with it the acting out of the exploitative dependency needs. This is undesirable on two counts: first, because of the inevitable resentment aroused in the therapist as the patient becomes more and more demanding, and second, because, with this type of permissivity, the patient is led to expect that his pathological pattern of seeking gratification will work and therefore need not be given up. This pathological pattern of interaction between the patient and myself characterized our treatment relationship until the last six months. During the time that it was predominant, it underwent some vicissitudes in the sense that after the patient's first psychotic episode I was no longer an active participant in it, but rather an unwilling victim of it. It was the chronic resentment and feeling of helplessness to handle the situation which led me to agree to the patient's discontinuing treatment in 1950. By the time we resumed in the summer of 1952, I had recognized

the pathological elements in our earlier relationship, and I now attempted to define limits beyond which the patient would not be permitted to go in his exploitative behavior. This led to a hostile interchange between us following which the patient apparently accepted the new definition of the situation. For instance, he accepted the fact that he was not to use my telephone or to enter the office before he was requested to do so. However, setting the limits had in itself no effect on the patient's basic problem. It merely defined the situation now as being that he had previously been a bad boy in taking advantage of the doctor and he was expected to behave better if the doctor was going to go on seeing him. The fact that good behavior is so completely and totally the patient's goal as far as human relationships are concerned has been the main stumbling block in working this pattern out. The patient does not follow the expected pattern of an analysis and in making demands, experiencing frustration, expressing his anxiety or his resentment, and then recognizing the pathological elements in his behavior and being able to change his goal. Instead, he expresses a demand, experiences frustration, and then attempts to repress the disapproved type of behavior. This means that as the frustrations accumulate, the patient carries an ever-increasing load of tension, the tension being partly a matter of his unfulfilled needs and partly a matter of his resentment at their lack of fulfillment, all of this being kept out of awareness. With this

particular patient, the repeated manic attacks appear to be an actual explosion resulting from this type of accumulation of tension. Following the extremely acute psychotic episodes the patient appears relaxed as a child does after a temper tantrum and is able to reenter the real world until the tensions accumulate again.

Case 4: Mrs. C.

This patient was hospitalized in 1945 in a hypomanic state in which the prominent symptoms were restlessness, irritability, and sexual promiscuity. This case study has been prepared from the voluminous hospital records, which contain a large number of letters exchanged between the therapist and the patient's mother. This correspondence, which sheds considerable light on the mother's character, as well as on the mother-daughter relationship, is extensively quoted here. The patient herself wrote a great many notes regarding her subjective experiences during her psychosis. Some of these are also quoted here for the insight they give into the nature of the patient's experiences in her depressed phase.

At the time of her admission to the hospital in 1945, Mrs. C was 21 years old. There was a history of mood swings from depression to elation since age thirteen, but these had not actually assumed major proportions until age eighteen. At that time, after graduation from high school, the patient had left her home with a maternal aunt who was only one year older than she. The two girls had gone to Florida to take a training course offered by Western Union, and had subsequently been given several assignments in small towns near military installations.

Up to that time (1942), the patient, although proficient in sports and reasonably popular with her friends, had generally been regarded

as more quiet and retiring than her aunt. Now, however, she became considerably more active and outgoing; she was especially popular with young men, and had gathered quite a large group of admirers. At first this change was looked upon with favor, and it was felt that the patient was at long last gaining in self-confidence and that she was coming into her own. But it gradually became apparent that her expansiveness was going beyond normal bounds. She became hyperactive, overtalkative, demanding, and extremely irritable. Where she had been previously rather modest and reserved, she was now provocative and seductive. Her vocabulary was enlarged to include the frequent use of the more primitive Anglo-Saxon words. All efforts by her aunt to talk to her about her actions were met with anger and resentment.

The patient soon (1943) became rather deeply involved with two young men. One, a sailor, was somewhat of a spendthrift and alcoholic; he was gay and charming in manner, rushed the patient, and spent a great deal of money on her. The other, Ben, a soldier, was less flashy, but apparently no less devoted. She carried on affairs with both of these men, and finally had sexual relations with the sailor. She told her aunt of this, and was evidently quite disturbed and anxious for several days. She had found the experience unpleasant and suffered pangs of conscience. She soon became hyperactive again, however, followed Ben to a distant camp, and registered in a motel as his wife. The aunt

became disturbed at this, and called the mother, who came and found the patient and Ben living together. Ben wished to marry the patient, but the mother objected, feeling that it would not be a good match. (The reasons for this are not given in the history.)

The mother and patient started back home, and on the way the patient developed arthritis in one knee. She was confined to bed for over two months, and during this time she gradually became depressed and underactive. At first there was some recrimination and anger at the mother for interfering with the marriage, but soon the patient became quiet and actually dependent. The mother, who had previously felt hurt because she considered herself unwanted by her daughter, was now concerned with mollifying her husband, the girl's stepfather, lest he become impatient and refuse to support a grown young woman who did nothing to earn her board and keep; hence, when the daughter now finally turned to her, she more or less rejected her. It was in this setting that an old high school boy friend, now a Navy Petty Officer, returned home on military leave. This young man, Joe, had always had more money than most boys since he owned a boat which he chartered to fishing parties, spending the summer in New England and the winter in Florida. In high school days the patient had been a frequent visitor aboard his boat, but there had been no serious attachment between them. Now, however, Joe spent almost every waking hour of his leave with her, and pressed her to marry him. She was quite reluctant, but he finally told

the mother in her presence that they were going to get married. This time the mother urged the patient to marry--motivated as much by the memory of the daughter's recriminations because she had broken up the relationship with Ben, and by the desire to get the patient out of the house, as by any feeling that Joe was a particularly good match. The mother provided money for a wedding within a week after the announcement. Before the wedding, the patient hoped that something would come up to interfere with it, but when nothing did, she went through with the ceremony and went off on a short wedding trip. Upon her return she appeared quite depressed, told her mother that she had found sexual relations with her husband distasteful, and made some vague remark to the effect that she feared she was changing into a man.

Gradually, in the late summer and fall of 1944, the patient became more aggressive, active, and hostile in manner. She told her mother that she had been dead for five months and that she was never going to let herself die again. She went away to be near her husband's home port, and began working again. Very shortly after the marriage, the husband developed gonorrhea, and at first the patient thought either that she might have infected him or that he had been driven by her coldness to consort with prostitutes and had thus contracted the illness. Both patient and husband were examined at the Naval dispensary and he alone was found to be infected; he maintained that it came from a contact

about two weeks before the marriage. All this served to make the patient even more irritable. This incident made her husband feel responsible for her behavior in the following months.

The patient's hyperactivity became more marked, and eventually the patient's stepsister accompanied her on a consultation with a psychiatrist, who wished her to return for psychotherapy. The mother urged this, but the patient, who had by now become very bitter against the mother, refused to go, and in this was supported by her stepsister. Consequently, matters rapidly went from bad to worse. In the fall the patient went to Atlanta upon the urging of her husband's younger sister, who, it developed, wanted to have her along to cloak some sexual activities of her own. With her, the patient also soon embarked on a series of sexual adventures. Several months later she went to Washington to work, where she stayed with her aunt. There she continued her sexual adventures. One month after coming to Washington, she was admitted to the hospital; the hospitalization was arranged by the mother, who had been called by the patient's aunt.

Family History.

The patient's early life was notably unstable; some of the letters from the mother will be quoted at length in order to give a clearer picture of the early environment. Little is known about the father. His grandfather and father before him had reputedly been members of prominent

families who had married "beneath" them. The patient's father had been raised by his mother, since his father had deserted the family. The mother's death in a state hospital was quite a shock to the son, since he was unusually close to her. Mrs. C's father is described as a very unstable, suspicious, and irascible person. Mrs. C's mother, who considered him to be jealous, over-bearing, and sadistic, said at one time that she knew she would divorce him within three months after she married him; she actually did divorce him when the patient was three. From that time on the patient had only occasional contact with him, although they lived in the same town. He drank heavily, worked irregularly, and was frequently jailed for one misdemeanor or another.

The maternal grandparents were Norwegian, the grandfather a fisherman. The mother was the third child, and the eldest daughter of a sibship of seven, three of whom were girls. One of the older boys died in early childhood, and the middle girl was hospitalized for a period in a state hospital with a diagnosis of schizophrenia. The grandfather was an autocrat who was feared by his children. Among other things, he is said to have inducted his three daughters into sexual activity when they reached puberty. (A statement that the patient was treated in the same way by the grandfather appears in the history, but no further details are given.) The grandmother refused to believe this when her daughters told her, and generally treated them coldly and harshly.

In a letter to the therapist during the patient's treatment, the mother wrote: "I was sixteen years old when I married. My parents, particularly my father, were very strict, and I wanted freedom. Naturally, I was in love with her father; one always is at sixteen. Most certainly I wanted to have Kay, but while carrying her, I wasn't sure I wanted her father. My emotions were conflicting. After she was born, I was thrilled with her. I was glad my baby was a girl, and she was so beautiful, I couldn't help loving her more than I thought I was capable of. Perhaps I was hoping and dreaming of the companionship we would have which never existed between my mother and I. We lived at home with my parents--the three of us, and, of course, I was with her constantly. My mother had her own family, but she said she was content for us to live there, but I would have to learn to take care of my own, which I was happy to do, for I loved her. I found my relations with my husband were becoming strained, for he was worse than my parents. He was very jealous, suspicious man, and inclined to be a little evil-minded. He found fault with all my friends, and I just wasn't permitted to go anywhere. I wasn't the type to go on under those conditions, so we separated. I stayed home with my parents; he left. I went to work in a local store. I had to work to support my daughter and myself, for I received no support from my husband. Naturally, I had to leave the child at home with my mother while at work. I worked in Tampa for six

months, but the wage level was pretty low. Nine dollars a week was hardly enough to live on, so I went to New York and worked until Christmas rush was over, and then went down to Florida. At the end of the hotel season, I returned to New York again. That was in 1927, when Kay was four years old. I became ill and went home; recovered some; worked for the summer, and in the fall returned to New York. I was ill again, so back home for the fall, the winter, and the following spring, when I had a major operation performed. When I recovered I came back to Tampa and secured myself a divorce in May 1929. Then a job again in Tampa, staying home with my parents. Between jobs in other cities, I came home whenever my finances would allow, for I was sending money home for Kay. It wasn't much, but I managed to give my daughter all the things a child could want for. My mother was very kind to her, and treated her as fairly as anyone could, with seven children to take care of. Definitely I wanted Kay and loved her very dearly. I was married on October 7, 1922, and Kay was born on July 9, 1923.^{1/} In 1930, I had remarried again, and my second husband and I went to Atlanta to look for work. Unfortunately, I again married for love, and the Depression was in full swing. I lived and worked there for four years. While here

^{1/} The mother later corrected this statement to the effect that she was three months pregnant when she married.

in Tampa, Kay refused to leave my mother to live with me, but she came to see me often. What my husband lacked in money-making ability, he made up in good disposition. We enjoyed each other's company, and had a good time in spite of no money. I had more happiness while married to him than I ever had. I had always been on the outside, watching my friends do all the things that I wanted so desperately to do. When I did do anything, I was punished in no uncertain terms. It seems like I didn't know how to take "no" for an answer. To get back, I am afraid I was willing to accept Kay's decision to stay at home with my mother. As time went on, my husband drank more and worked less. I couldn't live that way, and being young, impetuous, and impatient, decided if I had to work, I would support myself, only not him, too. I gave him money to come home, but we parted friends. I later met another man, a good steady man. Kay liked him. I wasn't too much in love with him, but I did decide to marry him for the advantages he could give Kay. But I didn't. My mother was ill, so I came home to help care for her. This was in 1934, when Kay was twelve years old. Mother died the following January in 1935. Then Kay and I went to live with friends. I fell in love with someone else and married, after a divorce, of course.

" I was always an independently minded person, not very demonstrative, so therefore most affection I may have had for anyone wasn't exactly worn on my sleeve. Kay I always loved and there was nothing

I didn't try to get for her. My first thought, in most all my selfish material gains, was to get her things I had wanted or didn't have; to go places that I always longed to go to. Hasn't she ever told you of all the good times she has had? College proms, high school parties, dances, rides, silly girl incidents? I can remember so many she has had. Those were the things I had worked for her to have, and believe me, I had to fight to get them. Anyway, Kay had always lived at home with my mother. The very first time she left my mother was in 1934. Naturally, with a gang of children, ranging from a year younger than Kay to 24 years older, there is bound to be dissension among them; jealousies, too. She wasn't exactly an easy child to raise. Somewhere along the line my mother had given her the idea that all the things I did for her I was supposed to do. Somehow or other, the attitude 'the world or my mother owes me a living,' became quite fixed. It took years for it to moderate and never quite completely."

Upon receipt of this letter, the therapist replied that he noted a tendency in the mother to view the patient's difficulty and their relationship in "nice" conventional terms. He stated that in meeting the mother earlier, he did not gain the impression that the patient had meant much to her except at intervals. He wrote, "I wish you could keep in mind that you are not a free agent, and that relationships are not developed and maintained on a voluntary basis but that you, as a product of your

unfortunate family, must have had difficulty very much along the same lines that Kay is having now. To tackle the problem with wishful thinking is self-deception. . . . It might help to realize that Kay cannot be benefited by any pretense of wholesale affection. Her interpretation of your all-out wish to be helpful to her now is that this is largely based on guilt feelings. It would help to keep that clear in your own mind. You say it seems inconceivable that she feels unwanted. But she was the child of a man you did not love. If you had not had her, you would have had more freedom, and maybe a better chance to find some happiness for yourself. Her presence made your third marriage more difficult and it certainly hasn't improved your relationship with your family."

To this the mother replied: "I think your letter was the most unkind letter I ever hope to receive. If you think I deserve the message implied, it's okay by me. I'll take it. But perhaps you may have misunderstood some of my letter. I am happy Kay has someone—you—that is truly interested in her and understands her and thinks she is above the average. Whether I receive any other nasty letter from you or not, I intend to speak my mind, not in defense, but to let you know that I do love my daughter. And my reason for helping her now is not largely based on guilt. If you could have just an inkling of the unhappiness I have had trying to give her the material things I thought she wanted, for she never showed any love for me, perhaps you would understand my

part. I always tried to protect her from the hurts that I had. I would never let anyone say anything about, or to, her, practically ruining all chances of what happiness I might have had with my present husband, because of the antagonism between them—the hate, the lies, the fights, insults, and many more things that I told you about, because I knew she wasn't happy. You wouldn't wonder at my attempt to bring my relationship with her to nice, conventional terms. How could anyone love a child, except at intervals, who found fault with the men you married, the way I dressed, combed my hair, talked, kept house; just everything I did was wrong. Everything everyone else had or did was better than what I had or did. I tried darn hard, but I'm not, as I told you, a long-suffering person, and blow my top plenty when I could stand it no longer. Is that so awful—to want to be treated like a human being? I hated to go anywhere with her with other people, for her contempt for me was always so obvious. Perhaps this sounds like self-pity, but I don't care. I did and I do love my daughter, or else I wouldn't and couldn't take all the things that have happened to me and been said to me. To tackle the problem now with wishful thinking and self-deception—of course, it is—but what else have I to hold onto but wishful thinking? What else? I don't even have the love for my husband to help me along. I still say that it is inconceivable that she feels unwanted by me. I know my husband doesn't want her; he is jealous of my love for her, and knows,

because I have told him, that the only reason I have stayed married to him is because of the things I could give her. Her treatments right now would be impossible if I weren't married to him. True, I am frightened to death of insanity, but I have gone out in the world by myself and worked, and could do it again, as much as I would hate to. Right now I am tired to death of working. I have done it for many years, and would hate to give up the things I have, but whether you believe me or not, I fully intended to get what I could out of this match of mine, and go with Kay if she wants me. I went so far as to see a lawyer about it, but, of course, that, I suppose is mere dramatics. I didn't tell you that I didn't love her father when she was conceived. I was very much in love with him and wanted her. It was after she was born that I found that he was not what I expected a husband to be that I changed. Then it was that I craved more freedom and wished I hadn't married, and I can't understand why you say the relationship with my family is strained. They know that I have fought tooth and nail for her, and have never thought of questioning that. Why should they? The ill feelings there may have been between my brothers and sisters and her was all kid stuff; believe me, they are just as concerned over her as anyone would be over someone close to them. My brother offered me help if I needed it. Another has children and can only offer sympathy, which is sincere. And another is in the Pacific, writing letters full of concern for her —so why does

she feel that way? If I could think of anything to help her, I would be glad to write. Perhaps you can help with more questions. It is bad enough to be working the way I am, without receiving a letter with such a sound to it. Darn it all; haven't I had enough? Kindness is the one thing I have truly prayed for, and all I get is unkindness. I must invite it unknowingly. "

These letters are fairly typical, and reveal the varied aspects of the mother's reactions. At times she was frank and straightforward, apparently ready and willing to describe events relatively objectively. But in five years of correspondence during the therapy, hardly a letter came which, along with the concern about the patient, did not also express her own unhappiness and describe the burdens and difficulties under which she labored, as well as the frequent fear that she would not be able to carry on any longer. Nevertheless, there was a steadily increasing honesty in her letters, and they served to give a more vivid understanding of the patient's early life. Concerning the patient's father, for example, she wrote:

____ "About Kay's father, I'm afraid I can't tell you too much about him, because I was away a good deal, and didn't see too much of him. But as I remember him, I guess he was sort of a pathetic person, or at least I always had a feeling of pity. He had no real home; no immediate family; no decent jobs, at least in my opinion, and no real character.

He did have a great deal of love for his mother, who was dead—but, as I heard, had an unfortunate life and death. She died in a state hospital from drink and a change of life. I knew none of this when I married him, and was truly shocked when I did learn of it, and I guess I used it cruelly when we had any differences. I was brought up rather narrowly, and acted as all ignorant people do. I guess that my family sort of ridiculed him, because he was different than we. He was a very nervous-acting person; would jump up from a chair, pace, and wave his hands around when excited or talking or trying to squeeze information from people. He was an extreme gossip, and always prying. He never liked any friends I had, and was terribly jealous. All these things got on my nerves, and we quarrelled a good deal. One habit he had I hated. When we were talking about anything in general, I had to give a minute description and repeat the same thing a dozen times, and he would sit there with a gleam in his eye, tapping his foot nervously, especially if the conversation was about someone. For instance, I saw him downtown the other day and he asked for Kay. I said she was fine, to avoid what I knew was coming. He said, 'Tell me, Elsie, is she mentally off? Is her mind gone? Or is she—well, you know what I mean.' I got, as I usually get with him, exasperated. I told him, of course, she wasn't crazy, for that is what he meant. He said, 'Well, tell me about her; you know, tell me all about her.' And while saying this, he is first

on one foot, then the other, waving his hands around with that damn gleam in his eyes. I, of course, got mad and said, 'I have told you a hundred times that she is ill—mentally ill, but not the way you mean. She is just unsure of herself.' He then asked me the same question: why did it happen? I replied I didn't know, but the doctors were trying to find that out. I'm sorry I told him anything at all, for he drinks a good deal, and perhaps talks more than he would otherwise. I know that is so, for he and a mutual friend were having a few, apparently, for this friend visited my sister a short while after and asked for Kay, and remarked what an awful thing had happened to the poor kid. My sister told me, and I confronted Kay's father with that, and he denied it, so I must believe him or my sister. Sometimes I wonder, for my sister's not too apt to tell the truth, since she hasn't been well, but that's another story.

"After we separated, he went back to live with his aunt, six or seven times removed, who was fond of him, but pitied him because of his peculiarities. She threatened to put him out many times on account of his drinking. He is very secretive about his personal life. I have never known him to take any girls out openly, or at least around Tampa, and consequently a great many people blame me for his drinking. They didn't know, as I did, that he drank before we were married. He has never been anywhere, nor done anything of importance, but talks of the

one time he went on a merchant marine ship for a month or so to Algiers, so he said, as if it were the most important thing in his life. I have heard about that trip a thousand times. He has worked in a shoe store off and on all these years, always talking about quitting the coming season, whichever it might be, and going out of town. I have heard that for 21 years. I really feel sorry for him; why, I don't know. I can't stand him more than five minutes at a time. I try very hard to be kind because of this pity, but the minute he starts pacing, jumping, moving his hands, and that damn gleam comes, I get exasperated, and usually end the conversation in a hurry. He always was free to visit Kay whenever he wanted to. I don't know whether she ever cared a good deal for him. Our attitude, I can see now, didn't help that much. As she got older, she went in the shoe store to see him occasionally, but not too often. I always spoke to him when I saw him. I guess I was relieved to be shed of him. There have been times when Kay would do, say, and act like her father. She would gesture, tap her foot, glance at me like her father, and the same feeling of exasperation would come over me, and, of course, I would say, 'Damn it, Kay, you look just like your father when you act like that.' Well, that is all I can think of, and I hope it helps some."

About two and one half years after the patient was admitted to the hospital, the mother wrote as follows about the patient's early life:

"It occurred to me yesterday while listening to two girl friends tell of the scrapes their children got into when babies, such as spilling perfume, and waste baskets, pulling tablecloths, spilling beans all over the floor, and so on, I don't remember Kay doing any of those things, rather anything naughty, such as those things I mentioned. Now, what is puzzling me, did she do any of them, or don't I remember her doing them? And I've tried so hard to remember, but I can't. I have no one to check with. My brothers wouldn't know—most men are stupid. Mildred was too young, and Clara isn't around. It's bothering me. I guess I didn't get the significance of her letters. The thing that stands out most clearly is this—I never knew where I stood with Kay. I never knew whether the thing I did or would say would please her. She was coldly sarcastic, aloof, and hateful to me, especially when she thought I was trying to make an impression—you know what I mean—when I would try being a little ultra, lift my voice, smile prettily, and don the oh-so-modern-mother act—all women do that, you know. And there were other times when I really was trying to please her, and she would have none of me."

A little later she wrote the doctor, "I told her of my experience, and, believe me, it cost me quite a bit to disclose the secret that I have kept pretty much to myself all these years. Because you told me to, and because I wanted Kay to see that I had received no love from my family, and to explain my lack of family spirit; I thought, perhaps, she would

see where I, too, wanted love and understanding, and not finding it at home, went elsewhere looking for it, and consequently getting into a lot of messes and neglecting her.

"When I spoke of the similarity of our experiences, I meant it to be a helpful comparison; for instance, when I first told you I disliked my mother, and that I was ashamed of it, you pooh-poohed it and said that many people feel that way. I was really amazed and relieved to know that I was no particular kind of a monster. When I wrote that letter, I wasn't afraid so much of shocking her, but rather of making her ashamed of knowing of the sordid secret. Doctor, the strained and unpleasant relationship between Kay and me has been forgotten by me. I know of things that I have done that helped that situation to exist, so I feel partly responsible. I have been selfish and self-centered. Had I been less so, and gone without the things, whatever it was at the time; sacrificed some of that so-called freedom, I would have been a better mother. Or would I? There is still that home life of mine to have contended with, and, too, when Kay first became ill, before I realized it, I mean, she was the nicest she has ever been to me—kind, thoughtful, and pleasant, and wanting to be with me. As a matter of fact, it was embarrassing to me because I didn't know how to handle that situation, either. I muffed it, as you know. Seriously, that month or so helped to erase many unhappy memories.

"Actually, I don't like children. I am afraid of myself. I could be terribly cruel—murderously so. I don't know of any child I've had a real, lasting affection for. If I'm not around them, I forget them. I am truly sorry my letter upset Kay. I wasn't looking for sympathy. I think it was just around the time I wrote to her that someone had accused me of being a hard-hearted so-and-so because I haven't visited my father since Margaret's death. A few words were tossed back and forth on the subject. Why does that discussion always end with, 'After all, he is your father.' Perhaps my letter was looking for sympathy, after all. I was really writing her why I don't want to see my father. My mother being dead, he must assume her deeds."

The "secret" referred to in the foregoing excerpt was the fact that the mother had actually been three months pregnant with the patient when she married the father, and that she had run around with men a great deal. In fact, when the patient was three, the mother had been more or less forced by social pressure to leave town because she had been carrying on an open affair with a prominent married man, the father of five children.

Later she told the therapist of having tried to smother the patient with a pillow when she was an infant, thus completing the picture of a relationship which ranged from the greatest indulgence to the greatest degree of rejection.

To complete the description of the patient's early life, after her parents' divorce, as mentioned above, she was, in effect, brought up by her grandparents, almost as their youngest daughter. She seemed closer to them than she was to her own mother, whom she saw only irregularly, and to whom she apparently did not form a strong attachment. When the mother married for the second time, the patient refused to go to Atlanta to live with her, but chose to remain with the grandparents.

After the grandmother's death, when the patient was eleven, the grandfather employed a colored housekeeper who proved to be unusually kind and warm in her attitude toward the patient and her young aunt. Some time later, the mother found her father and this housekeeper in bed together, and was so incensed about it that she took her daughter away, over strong objections, to live with her and her third husband.

The patient and her stepfather disagreed, as did the mother and her husband's daughter by his first marriage. The patient got along fairly well with her stepsister, who was about six years older than she, but the relationship with her mother was strained and unhappy, as has been described above.

After being forced to leave the grandfather's home, the patient became mildly depressed. In the following six years prior to her graduation from high school there were several alternating periods of

over-and-under-activity. The record does not contain details as to possible precipitating events, nor are the episodes described in detail. However, it seems that they are clearer in retrospect than they were at the time of their occurrence, when they were not regarded as being remarkable in one way or another. In fact, the slightly "high" periods were rather welcomed as evidences of increasing satisfaction on the part of the patient.

Treatment.

The patient was under treatment as an inpatient and then as an outpatient for almost five and one half years, all but the first two months being with the same therapist.

The correspondence between the therapist and the patient's mother, and the reports by the therapist to the hospital staff, comprise an unusually interesting document. Even from the few samples given, it can be recognized that he established an excellent working relationship with the mother; and although the therapist's letters were relatively few over the course of the years, the exchange between them was very productive. Not only did the mother become aware of attitudes in herself which had hitherto been unconscious, but a real change was brought about in the mother's attitude toward herself and her daughter.

But if the work with the mother could serve as a model of economical interpretation and productiveness, the work with the patient

(as seen in retrospect) could not. On admission in January, 1945, the patient was somewhat hypomanic and irritable. She had difficulty in making up her mind, and criticized her doctor for permitting her to do whatever she finally did do. She became involved in sexual relations with another patient, and also with a new aide, who was thereupon promptly discharged. She became increasingly excited. Finally, after she was given two weeks' sleep treatment, and was beginning to become depressed, she was transferred to the care of a second therapist.

The second therapist began by seeing the patient as being misunderstood and mistreated not only by her family, but by the first therapist as well. In the early months of treatment, he fell into the role of the one person who understood how miserably the patient had been treated—not only before she came to the hospital, but afterwards as well. She had come for protection against her promiscuity, and had not been prevented from engaging in that in the hospital. The aide to whom she was attracted had taken advantage of her fondness for him.

During this period, many of the details of the history given above were elicited. She described the content of her depression in terms of a feeling of hopelessness—she felt "flat like a living dead person"—and extreme discouragement. She loathed herself; for example, she would look at her hands and feet and find them "awful." Motor activity was

not itself difficult, but she lacked initiative; her thoughts seemed to "race"; she felt confused and unreal as if, in her memories and in her relations with her family, she were someone else. When she was "high", she did not feel elated, but seemed to derive satisfaction from putting things over on people, and from doing things she could not do at any other time. The depressive periods seemed to follow situations in which she felt let down by some significant person whose behavior seemed to reveal a lack of interest in her, or a lack of consideration for her. The high periods seemed to follow feelings of guilt on her part for behavior toward others which, in effect, constituted letting them down.

The patient gradually became more depressed, and by May, 1945—five months after admission—she was practically mute. The therapist interpreted this as possibly being due to the fact that he had been slow in seeing how the hospital had reduplicated some of her mother's neglect of her; therefore, he, too, had "failed" her. He also felt he might be in the position of the grandmother, who had been kind to her mainly to demonstrate how inadequate the mother was. The patient did not confirm or deny these possibilities. Under amytal she said she was confused and thought in circles; every thought immediately brought out some equal and opposite thought. She felt that something awful was going to happen, but did not know what or why. After considerable discussion of the utility and futility of guilt feelings by the therapist, the patient finally

began to talk of some of her escapades, and her mood improved.

By July, 1945 she was apparently making good use of therapeutic time, and the general situation appeared so promising that she was permitted to move out of the hospital, continuing treatment as an outpatient. She was given a job as an aide to enable her to pay for therapy, since it appeared that her mother could no longer advance her any money.

It is difficult to reconstruct the content of her therapeutic work at this time from the notes available, but it does appear that the patient gave considerable detail about her relationships with men, and in so doing, revealed much conflict about these activities. The therapist felt that the patient had an excellent relationship with him, but did report that she was quite resentful toward the hospital. She became bitterly critical of a new nurse who had asked the supervisor whether one of the patients was mentally deficient; the patient angrily denounced the hospital for having such a person on its staff. She became quite depressed when an alcoholic patient, who was being treated by a senior psychiatrist, was admitted and discharged several times in the space of a few months without any apparent change in behavior. There were a number of other evidences of increasing tension, most of them expressed in themes similar to those implicit in the examples quoted above. It appears that these were not considered as expressions of transference feelings. In the fall of 1945 the patient went into town with another young female

patient of the same therapist. Both of them drank a good deal and became rather sick; Mrs. C then called the therapist to tell him what had occurred and to ask him what to do. He suggested that they take a cab back to the hospital, which they did, and she was again admitted as an inpatient.

This episode marked the overt onset of a prolonged period of disturbance. Just what had passed between the two girls was never formulated. They each spoke of having hurt the other; competition for the therapist's interest may have been what was involved, but this is not stated in the notes. During the ensuing months, the patient was hostile, aggressive, destructive, and most uncooperative. In a period of six months, she ran away from the hospital no less than fourteen times. These "escapes" followed a regular pattern. While out with one or even two carefully instructed aides or nurses, she would elude them, outspint them, and disappear from view. She would then call her therapist, tell him of what had happened, and warn him not to try to follow her; she would then return to the hospital after periods varying from several hours to several days. On one occasion she travelled several hundred miles to see the married attendant with whom she had had sexual relations shortly after admission to the hospital—ostensibly to break up his marriage. A repetition of the sexual experience occurred, but the adventure ended with his wife (a nurse) bringing her back to the hospital.

These escapes and the possible reasons for them became the focus for considerable disagreement and even recrimination among the various staff members who were involved in her treatment. Finally the administrator and therapist banded together against the rest of the staff and instituted a program by which the patient was literally confined to the disturbed floor of the hospital for over a year. The notes which follow were written by the patient during the early part of this period, and give some idea of her feelings during the early months of her incarceration.

"Why was I born? Analyses, hours, doctors, problems, homicidal, suicidal, seniles, is this life? Is this what I am living for? Probing into my affairs. Why must I see that which hurts too much to even think about? Expectance of getting along with people when all I feel is irritability. Is it my surroundings, or does it go back further? Why was I born? For bitterness, sodium amytal, unhappiness, misery, gloominess,—events that should never have happened. Am I lower than a worm? What made me that so my actions, reactions, my responses, or what I think other people think of me? Why should I care what they think? I hate viciously men, women, children, everything that mars the earth. Every living object that walks the earth. Why must I be reminded of all these hatreds? I have seen too much, heard too much, too many things have happened to me. All but attention, love, affection.

Damn my grandparents, damn my mother. They're the cause. Why must I suffer because of them? Why were they stronger than I? Why didn't I hurt and hurt the way they hurt me? Uncles—men—hatred, revenge. Aunts—women, hatred, revenge. Although I hate each sex because of different reasons, the motive is the same. Why can't I be like other women? Why can't I be satisfied with an ordinary life? I hate ordinary beings, they are so dull and lead such dull lives. Pathological liars. Why must I be among them? Oh, yes, I've stayed in the Blue Room of the White House. In that painting on the cover, I painted that. What am I to believe? How can I tell truth from untruth? How am I to know what I say and think is the truth? Mystery, eeriness, never knowing the answer. Can't look at the end of my life. Must go backwards, dig up material that I think unimportant. Material I want to forget, must forget. Distrust—distrusting people when it would be profitable to trust. Is it healthier to trust than distrust? Everything and everyone is questionable. Are there answers? Must I find my own answers? To hell with life, I want to die. Why haven't my attempts been successful? Have I unconsciously prevented them? Why do doctors try to show us that there is something worthwhile to living? Why should we take their word? They have a profession, an object to live for. What is my object—at present to move to another floor. It isn't worth the effort to struggle. There are two of me, perhaps more. But is there

anything in the two people? Why must I be a stranger to others and more important to myself? Self-esteem—down to my last quarter of an inch. Why did I let it lower? Wouldn't I have been better off if I didn't care about my self-esteem? Jealousy!! I'm jealous of everyone walking the streets. I'm a girl locked up in a mental hospital. I need protection from myself and other people. A girl, twenty-two, young, wanting the life of a young woman. Locked up, can't believe it, won't let myself. I see nurses and student nurses my age on the road to a career. What I do is brood and think I must leave. I'm going to run away. I can't be locked up any longer. People that should not be seen—on the violent floor. Why? Because I run away not only from the hospital, but from myself. What do I gain? I always come back. I always do something to lower my self-esteem. Is it worth it? Yes, no, two sides again. Yes, to get away from my dissatisfied environment. No, because of what it does to me. How did it all start and why? My childhood, or does it go back to my mother and her daughter, etc. It's like climbing stairs in the dark. If I miss a step, I'm down at the bottom. I must carefully descend the future. What do I like? Music? Boogie, instrumental—books, nonfiction, sometimes a historical novel. Sports, practically all, particularly swimming and sailing. Dancing, smooth dancing. Interest—escaping myself. Questions asked of me. Sex, masturbation. Subjects I was not allowed to talk about when young.

Leo and I knew the answers. Sex—it means different things to all. Masturbation—I won't and can't talk about. Defenses—the glory of us all. Mine happens to be toughness—just out and direct toughness. Beings not knowing symptoms of mental illness recognize it as it is—psychiatrists recognize it as defense for hypersensitiveness. How can beings be called human when they are eager to type people and condemn them? How can they think themselves human?

"Religion—it leaves a bitter taste in my mouth. Leads people astray, keeps them ignorant and in the dark. Who are priests and nuns—people mentally ill, escaping life and themselves by believing in something beyond their power to control. Such a subject infuriates me. Why can't a sensible believing faith be established? Is it too complex to solve? Why should we leave it up to people that have never lived, people tied in knots through their own misery?

"Analyses, what can it do? Is there more to it than believing in a wooden object? What happens to an analyst's patients when he dies? How can a patient continue? All that was gained dies with the doctor.

"Will it help me? Look at her in the corner, she has been here for years and shows no improvement. How am I to know that I will not be the same? We mustn't compare ourselves with other patients, but it's hard to avoid it.

"Impulses—to strike, murder, kiss, seduce—so strong. I never know what I will be doing the next minute. If I strike, I will be locked up in a room. Is that treating us as humans or as children being punished for misbehaving?

"Packs—ice cold sheets wrapped around the nude body for three hours. It's hell trying to go into one, but if I fight and struggle, I don't feel the coldness of the sheets. I also get a chance to kick, scratch, bite. You get warmer and warmer, bones ache. Count the minutes, become angry at the unfairness. The two hours finally is up and you get out and must hold the anger in to avoid another pack.

"Modesty—is there such a thing in a mental hospital? Men strip and put you in the pack, ask how much toilet paper you need. What is it?

"Protection—that is a laugh when you see some attendants sixty or seventy years old take advantage of a girl very confused. Should it be told—

"We are to take everything with a smile and never give up because our goal is happiness. All we hear all day long is wait, in a minute, don't, stop it—words, words—words that have no meaning—minutes turn into hours that drag endlessly through the day. Songs, voices, whistling—everything done to annoy everyone. Same song all day long, same thought all day long, can't stand it, won't stand it, I'll run. The

opportunity will not come because I am locked up and am not to go out for a half-hour walk with an attendant. They are protecting me, but it is done fairly—are they going half way? They are just thinking of the name of the hospital and not of the patients' feelings. Women thrown together. Women that hate the same sex—hate, despise, hate to think yourself a woman. The horrible sex that drinks milk out of saucers. Ruin other women because of envy, jealousy. Revenge—men and women. Want to wrap men around my finger and watch them squirm. Want to hurt women so much that I'll break up marriage after marriage, then laugh in their faces because it wasn't worth it. All I wanted was revenge and I got it. Was it worth it? Perhaps for the time being.

"Although my hatred for men is great, I want to be in their company. I feel at ease and comfortable with them. Perhaps because women look at me critically and men desire me. I don't like the latter, but it's better than critical eyes that seem to haunt me. Trying to write with all kinds of interruptions. Is there any place in this Godforsaken hall where I can be alone? Must I always be reminded of people that I hate and would like to see destroyed? Am I safe—could I control my feelings if living on the outside? Could I evade it and people? It couldn't be more miserable than this and what is this? The best mistreatment in the world. Lies, cheating, stealing, all I see every day. Perfect environment for me who hasn't lived a sheltered life. The best

I have in my life is termed hostile. That, because I can pick the man instead of letting him drift into my fantasy. I can't have sexual fantasies because of my anxiety. Something always interrupts them. Then, too, perhaps, so I won't be disappointed with the man. Lust is left in the dark and some day I'll have it freely and spontaneously. Blues all day long—feelings not properly expressed. Cover up for it, gay front while all the time I am crying. Laughing too much and loud hurts more. Not able to cry it complete and full of hell. All pinned up inside but the misery and hatred is greater than the need to cry. Praying for tears to feel human. Wishing for pain in hopes that there is something left. Fright is almost indescribable. So afraid you stay in your room day in and day out. Afraid of your thoughts and what could happen if you are in other people's company. The want to upset a card table, to slug someone on the jaw or the eyes. Knives not sharp enough to penetrate but on the tray every meal with an invitation to use. Forks, the divided prongs being asked to gash someone's throat. Dishes to break and use for destruction. Afraid that all those thoughts will overpower me, control me, am I responsible?

"Lights are shining in your eyes, disturbing the beauty of the night. Glaring in my eyes, bothering me when the only thing enjoyable to me is marred by yellow, ugly, glaring in my eyes. The reflection on the window. Misery. Flowers are thought to be lovely. To me they

are artificial, beings have to plant them. Beings scoured the earth, grass to show off their gardening experience. Why must man handle the only real and true thing in the world? Rain is protected from people. Use umbrellas, rubbers all the necessary precautions from catching cold. While to me, it's great to feel rain on my face, hair dripping wet, feet and shoes squishing as I walk. Girls hair becomes straight, now isn't that too damn bad? If only people can see things as they are instead of bustling about thinking about nonsense.

"What is there to talk about in an M. H. ? Food, not worth eating, backgrounds too awful to mention, people when the people here are not people, but symptoms. Kill me now, why must I wait to die a natural death?

"The sedative at night is as bitter as I feel. Fight it to feel relaxed if only for a short time. Want more to knock me out completely, hoping I'll never wake up. For what, for the same as yesterday, day before that, etc. Knowing other people my age all seem to have a good time, hating them for it. Why am I cursed, jinxed? Why should anyone have a good time, while I can't attempt it? Everything locked up--medicine, keys, the jingle of the Godforsaken things. Patients not able to understand why they can't have them. Nurses tormenting us by making them noisier. Are we expected to stand everything? Affection—how can we get it? No one able to give it to us. It's better to talk about

it, not therapeutic to have it. There is a little human instinct in us to want it and to try our damndest to get it even by getting near and playfully hug a crafty attendant. We are after bigger stakes than that, but the doctors want to protect us from any relationship — friendly, or otherwise. Shit. It's getting worse because I'm not too upset.

"Other patients acting very friendly when all the while they hate me. Why? Perhaps jealousy. Why should other girls be jealous of me? What do I have they want? If they knew how much I hate my looks and the trouble they have caused, they wouldn't want them, either.

"Patients having the analyst I have telling me they have an order to call him whenever they're upset. She's on the road to recovery. I haven't started yet. Telling how night doctors, always good-looking ones, going to talk to her for hours, while I can't get one. I'm on the disturbed floor, she in L. L. — the last stop before leaving. It doesn't make sense to me. Do you detect the subtle hostility? I do the same, but I can't brag about the doctor coming to see me. Yet, we're very friendly on the surface, but I suspect we wish each other dead.

"Trying to escape the noise of the floor by going on the porch, but only to hear the students giggling, having a fair time, but not the kind I want. They're only acting normal. Perhaps that's it — acting. A few men come and the laughter becomes louder, the girls gayer and supposedly charming. Isn't that acting for the sake of the men? Bitches and bastards is the only way I can generalize males and females.

"Whenever there is a tea on second floor, which is the hypocritical floor, the patients there leave. Perhaps they don't like to be reminded of what they may be like if they let themselves go. Then, too, perhaps they can't stand the competition.

"Nude bodies running around, ugly, human bodies. Body that neither man or woman want to see. She's walking and disguising masturbation while sitting on the porch or hall. Boy that uses terrible language. That is my environment for 24 hours a day.

"Having to be careful the way we sit while sitting on the porch. We can't relax and put our legs up, feel uncomfortable with shorts on because there was an attendant always looking, hoping to see something. He's been married for many years and has seen all.

"Having to live with a man I hate for two months because I am married to him. Running away from him in New York and then wonder how in the hell I got home. Dazed, complete mystery. Having to see him drunk. Tempted to shove him out a window, kicking, wishing him dead. Looking at him while he is asleep, wanting to kill him. Not thinking I'm married and tearing my certificate. While in the church hoping something, anything, would happen to stop it, but it goes on and I become a Mrs. I hate him, despise him, for taking advantage of my illness. Receiving letters from him describing his love for me and all the time knowing otherwise. Planning the wonderful life we're going to have together

and knowing that I hate him and would never live with him for a minute.

"Being depressed, slowed down and then the other extreme—excitement. Going to bed with men, knowing to me they're bastards, hating myself for going against my standards. Having my sister-in-law start me on my road to what I consider wrong. Having her hate me because I got the men she wanted.

"Moving to another city for whenever anyone gets to know my face or me, I shove on. Arriving and starting the same thing—sexual and dissatisfied relations, hating myself more, my self-esteem lowered . . . Wondering who I am, where I'm from. Why won't someone help me? Why doesn't someone realize I need help?

"Having my mother come and knowing of my actions. Finally seeing that I need a psychiatrist's help. Taking me at last to a doctor. He advises hospitalization. I refuse it. Won't make myself believe I need help. Finally agree and come here full of rich promises but none kept. Moved from one floor to another. Finally to four and not knowing what I have done to deserve such horrible treatment. Bewildered by it all.

"Letting myself go. Smashing lights, furniture. Kicking like a vicious wildcat. But it's been held in for many years, it had to come, must release itself.

"Locked in rooms for hours, days, weeks. Having a male patient always trying to kiss and paw me and making me hate him and myself.

Slapping him. He threatening to kill me. I try to get him, too. But he's really afraid of me, I have out-bluffed. I'm tough, too tough to hurt. Kay, the hailed, that's my name."

During the most excited part of her stay on the disturbed floor, the patient exposed herself repeatedly in front of her therapist, despite all his efforts to circumvent these attempts. When he would talk to her, she would shout, "I can't stand this talking," and interrupt him repeatedly for cigarettes, candy, or chewing gum. This behavior was interpreted at the time as being only hostile, but later developments indicate that it reflected dependent and sexual desires for the therapist. When one reviews the notes, it appears that most of the early interpretation offered the patient, although ostensibly free of value judgment, did, in fact, depict the patient as a vengeful caricature of her mother, totally without redeeming human qualities. In the fall of 1948, however, the therapist suddenly came to feel that he had mistreated all of his patients, and that he had not been honest with them or himself, but had denied his own intense responses to their behavior and to the remarks they had made to him. He told this patient and several others what he felt had happened, and continued treatment on the basis of a fairly frank expression of his own responses to them in the relationships, as well as his ideas as to the meaning and possible origin of their thoughts, feelings, and behavior.

At the time of this radical innovation, the patient had become

again more calm. She was disturbed by the therapist's statements, and seriously considered a change to another physician. She decided against this, however, and seemed to make steady progress in treatment.

In 1950, she was discharged from the hospital for the second time. This was ordered by the medical director against the therapist's wishes; the director felt that she could carry on as an outpatient and that this would be a more realistic arrangement, in view of the fact that she had paid just one-tenth of the regular hospital charges for over three years. The patient secured a job as a sales girl. She had several affairs; these led to abortive excitements which responded to only a few days of hospitalization. Finally, one of these affairs ended tragically, for early one morning she found the man comatose with a suicide note beside him. On the advice of others, she did not call a doctor for several hours (it was 5:00 a. m.), and when the doctor finally did come at 8:00 a. m. and started therapy for barbiturate poisoning, the man did not respond well. He died two days later.

The patient's guilt over this was not verbalized in any of the notes available, but the incident was followed by a rather marked change in behavior. She became more quiet, and ceased making her usual bitter remarks about the hospital. She started another affair with an aide who was also under treatment; he was an orphan, an apparent psychopath who had episodes of heavy drinking and sexual promiscuity.

Both the patient and her friend finally broke off treatment. However, a marked change in behavior occurred in both. They married, and the husband went to college and graduate school, taking a degree in the social sciences. The patient worked as a sales girl and then as a secretary, while the husband secured part-time jobs to help with the family finances. The husband now has a professional position; the marriage has prospered and they now have a child.

In retrospect, it would seem most likely that this was a case in which an intense transference neurosis was dealt with by a type of relationship therapy in which the patient's ego received support from the therapist's frank statement as to his past shortcomings. The marriage to a man who, in fact, had been as disturbed in his behavior as she, was a most fortunate one, in that it provided an outlet for mutually dependent feelings with less guilt than might otherwise have been the case. The relationship appears to have made for definite maturing in personality of both the patient and her husband— and while this is undoubtedly the result of their relationships to their doctors, it does not seem to have been based upon the gaining of insight. Although the therapist was severely criticized in staff conference, especially for the final step of telling the patient of his own feelings, it now seems probable that this was the only possible move at that point, since the relationship had, in fact, deviated far from even a modified psychoanalytic approach.

VII. SUMMARY AND CONCLUSIONS

An intensive study of twelve manic-depressive patients was made in order to reformulate, and further develop the dynamics of the character structure of these patients in terms of their patterns of interpersonal relationships. In addition to further developing our knowledge of their psychodynamics, we hoped to arrive at therapeutic procedures which would prove more useful in interrupting the course of this kind of illness.

A comprehensive survey of the literature was made in order to determine the present state of development of psychopathological theory in regard to manic-depressive states.

The manic-depressive character was investigated from the point of view of (1) the patterns of interaction between parents and child and between family and community; (2) the ways in which these patterns influenced the character structure of the child and affected his experiencing of other people in his subsequent life; and (3) the way in which these patterns are repeated in therapy and can be altered by the processes of psychotherapy.

Psychopathology.

Among the significant parent-child interactions, we found that the family was usually in a low-prestige situation in the community or socially isolated in some other way, and that the chief interest in the child is in his potential usefulness in improving the family's position or meeting the parents' prestige needs. A serious problem with envy also grows out of

the importance of material success and high prestige. We also found that the child is usually caught between one parent who is thought of as a failure and blamed for the family's plight (frequently the father) and the other parent who is aggressively striving, largely through the instrumentality of the child, to remedy the situation. And finally, the serious disturbance in the child's later value system (superego) is in part attributable to the lack of a secure and consistent authority in the home and to the tremendous overconcern of the parents about what "they" think.

A study of the major unresolved anxiety-provoking experiences of the manic-depressive indicates that the crucial disturbance in his interpersonal relationship occurs at a time in his development when his closeness (identification) with his mother has diminished but his ability to recognize others as whole, separate persons has not yet developed. This accounts for the perpetuation of his response to important figures in his later life as either good or bad, black or white and his inability to distinguish shades of grey.

Therapy.

As a result of our study of these patients, we found that our ability to intervene successfully in the psychosis improved. While all of the factors which contributed to successful therapy with these patients are by no means understood, we concluded that certain areas could be isolated, as follows:

Communication: The primary problem in therapy is establishing a communicative relationship, which is, of course, a reflection of the patient's basic life difficulty. The most characteristic aspect of the manic depressive's defenses is his ability to avoid anxiety by erecting conventional barriers to emotional interchange. We have learned to interpret this as a defense rather than a defect in the patient's experience, and we have found that when it is interpreted as a defense he will respond by developing a greater ability to communicate his feelings and to establish empathic relationships.

Dependency: A second major problem is that of handling the patient's dependency needs, which are largely gratified by successful manipulation of others. Since the manic depressive's relationships with others are chiefly integrated on the basis of dependency, the therapist is in a dilemma between the dangers of allowing himself to fit into the previous pattern of the dependency gratification patterns of the patient and of forbidding dependency in toto, since this is the patient's only means of integration. Furthermore, the therapeutic relationship in itself is a dependent relationship. The therapist must be alert to the manipulative tendencies of the patient and must continually bring these into open discussion rather than permit them to go on out of awareness.

Transference-countertransference: The most significant part of treatment is, as always, the working through of the transference and

countertransference problems. The patient's main difficulties with the therapist are those of dealing with him as a stereotype and a highly conventionalized authority figure who is either to be placated or manipulated, and by whom all of his dependency needs are to be met. The main difficulties of the therapist are in the frustrations and helplessness of trying to communicate with the patient through his defensive barriers and the strain of constantly being the target for the manipulative tendencies. These problems inevitably involve the therapist in a variety of feelings of resentment and discouragement which must be worked through. We have found that a recognition of the ways in which transference-countertransference patterns manifest themselves and vary from the patterns found with other types of patients makes the working through of this problem possible.

Problem of Authority and Defining Limits. One of the great risks in therapy with the manic-depressive is the danger of suicide when he is depressed or of the patient's economic and social security when he is in a manic phase. Much of the success in handling this destructive element must, of course, depend on successful therapy. However, we have found that a careful definition of limits and an appropriate expression of disapproval when the limits are violated is helpful.

Further Areas for Study.

We feel that the conclusions derived from our intensive study of twelve patients require confirmation by further investigation of a larger

series. A thorough statistical study of the families of manic depressives is desirable in order to confirm and elaborate the picture of the family patterns as we have developed it. And finally, a more intensive study of psychotherapeutic interviews with manic-depressive patients is needed in order to define more clearly the characteristic patterns of communication and interaction between patient and therapist, and to contrast these with the interactions in other conditions. This is a logical next step in advancing our knowledge of the psychopathology of all mental disorders.